

FORENSIC MEDICO-LEGAL REVIEW

Bertrand, Ricki Darren — DOB 27 February 1966, Ottawa, Ontario

A Multi-Modal Clinical Review: Imaging Findings Not Reflected in Official Reports

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CONFIDENTIAL — For Medico-Legal and Clinical Reference Use Only. This document is a preparatory analytical framework. Causal and legal determinations require independent expert clinical opinion with primary access to all source documents and DICOM data. The management of advanced HIV/AIDS-associated malignancy in this context requires palliative and curative care integration as a clinical and ethical obligation [1,2].

1. Abstract

PURPOSE

This analysis reviews the clinical and radiological record of Ricki Darren Bertrand (DOB 27 February 1966, Ottawa, Ontario) for patterns of clinical non-progression and imaging findings not reflected in official reports. Direct DICOM-level analysis was performed across seven possessed imaging datasets.

EVIDENTIARY PILLARS

- Imaging findings not reflected in official reports across six studies, including two CT chest reports (February and May 2021) that do not identify findings consistent with advanced GEJ adenocarcinoma [3], and two brain MRI reports (December 2020 and August 2022) that do not identify findings consistent with neurosyphilis.
- Upper GI endoscopy (OGD) was not performed across the reviewed clinical period, despite multiple independently documented clinical indications present from October 2020 through May 2021.
- HIV and syphilis baseline testing was not documented at any clinical contact in the reviewed period, despite a prior patient-initiated testing request that was recorded as outstanding.
- Incompleteness of the lower GI evidentiary record: a visible anorectal lesion documented in patient-held photographs was present at both colonoscopy encounters (September 28, 2020 and January 14, 2021) and is not referenced in either procedural record; no biopsy of that lesion appears in any reviewed document. The formal pathology report from the September 28, 2020 Provis Rudd colonoscopy has not been provided despite repeated written requests. The outcome of the January 14, 2021 colonoscopy is not confirmed in the reviewed record. These evidentiary gaps are addressed in detail in Sections 12.3 and 14.5.

METHODS

Direct chart review of Ottawa Hospital MyChart exports (July 2021), CHI chart exports (October 2020 – November 2021), and seventeen additional primary source records. Quantitative DICOM pixel analysis of seven directly possessed imaging datasets. All DICOM observations are stated without qualification; report-based observations from three studies not in the possessed series are identified as such. Inferential findings — including estimated disease stage — are labelled throughout.

MAIN CONCLUSION

The reviewed record documents a sequence of imaging findings not reflected in official reports, absent oncological and gastroenterological referral documentation, and the absence of established infectious disease baseline testing across a period beginning December 2020. Whether that sequence is consistent with the applicable standard of care is a question for independent expert review. The three most consequential evidentiary gaps are: (1) no upper GI endoscopy (OGD) at any point; (2) no HIV viral load, CD4+ count, or syphilis serology at any clinical contact; (3) no immunophenotypic characterisation of the station 11R EBUS-TBNA material. Each is addressed in the relevant section and framed as a standard-of-care question in Section 14.

2. Forensic Methodology

2.1 Analytical Approach

This analysis combines direct chart review with quantitative DICOM-level imaging review. Seven DICOM datasets are physically possessed by the patient and were reviewed directly: MRI Head (17 Dec 2020), CT Chest with contrast (6 Feb 2021), CT Chest without contrast (10 May 2021), RAD Chest (11 Aug 2021), Chest PA & LAT (15 Nov 2021 and 2 Jul 2022), and Ottawa Valley MRI Brain (12 Aug 2022). Three studies — CT angiogram (4 Dec 2020), PET scan (31 Dec 2020), and cardiac MRI (26 Jul 2021) — are not in the possessed series and are known through their reports only; this distinction is flagged explicitly wherever those studies are cited.

Findings described as inferential — for example, disease stage estimated from radiological pattern in the absence of tissue confirmation — are labelled as such throughout. The full source inventory, DICOM metadata, and exhibit catalogue are in Appendix A. Note on section numbering: Sections 4–7, 11, 13, 16, and 17 are reserved for supplementary analytical modules (CT DICOM analysis, MRI systematic series review, cardiovascular syphilis, and psychiatric characterisation framework) currently in preparation; their absence does not represent missing content from the core forensic narrative.

DICOM pixel analysis protocol: Quantitative pixel-level analysis was performed using pydicom and numpy. For T1-weighted series, a signal intensity threshold of >900 arbitrary units (AU) was applied to identify T1 signal above the analytical threshold; values are reported in AU with series-specific reference ranges. Whether signal at or above this threshold is pathological is determined by context, morphology, and series-to-series comparison, and is explicitly labelled as an inference where applied. For susceptibility-weighted imaging (SWI) and filtered phase series, paramagnetic signal was distinguished from diamagnetic signal on the basis of phase polarity; thalamic microhaemorrhage was confirmed where signal intensity exceeded 3 standard deviations below the local mean. Laterality convention throughout: in axial and coronal orientations, image-right corresponds to the patient's LEFT; in sagittal orientations, positive SliceLocation corresponds to the patient's RIGHT. This convention is applied consistently in all series-specific findings. DICOM metadata (acquisition time, series description, sequence parameters) is cited as the primary source for all pixel-level observations.

Fact and inference separation: Each analytical section distinguishes three categories of content. (1) Documented facts: observations drawn directly from primary source records, verbatim clinical notations, and pixel-level DICOM measurements. These are stated without qualification. (2) Identified inferences: interpretations of documented facts that require clinical reasoning — for example, estimated AJCC staging, differential diagnoses, or proposed causal relationships. These are explicitly labelled as inferential and assigned a confidence qualifier (Moderate, Conditional, or Speculative). (3) Standard-of-care questions: points at which the documented record is compared against a stated applicable standard and referred for independent expert determination. These are framed as questions, not conclusions. No causal or legal determination is made within this analysis.

Source weighting and image cross-referencing: Primary source records (original clinical notes, procedural reports, laboratory results, and DICOM data) are the evidentiary foundation and are cited by exhibit reference throughout. Secondary sources (published guidelines, clinical literature) are cited by Vancouver reference number and used only to define applicable standards, not to

establish facts. All radiological findings and photographic observations are cross-referenced to their companion image files as catalogued in Appendix A.10 (patient-held photographic documentation) and Appendix A.2 (directly possessed DICOM datasets). Where companion image files have not yet been formally reviewed (as noted in Appendix B), the corresponding findings are qualified accordingly.

2.2 Record Sources

Records reviewed span October 2020 through August 2022 and include Ottawa Hospital MyChart Health Summaries (three exports), CHI/OICC Chart Exports (October 2020, December 2020, January–November 2021), seven DICOM imaging datasets, radiology and pathology reports, clinical correspondence, laboratory panels, and third-party primary source documents. The full document-by-document inventory is in Appendix A.

2.3 Record Gaps

Four gaps most directly affect the forensic opinion:

1. No upper GI endoscopy (OGD) was performed at any point in the documented clinical period. OGD with directed biopsy was the investigation most directly capable of confirming or excluding GEJ/gastric adenocarcinoma at the primary site. Its absence is the single most consequential gap in this record (see Sections 8.2, 14.4).
2. No HIV viral load, CD4+ count, or confirmed HIV-1/2 antibody/p24 antigen test was ordered at any clinical contact in the reviewed period. No CD4+ count appears anywhere in the reviewed documentation (see Section 10.1).
3. No immunohistochemistry panel was performed on the EBUS-sampled material at station 11R. The intraoperative R.O.S.E. positive therefore remains uncharacterised as to cell lineage (see Sections 8.1, 14.2).
4. The formal Provis Rudd Endoscopy pathology report from the September 28, 2020 colonoscopy has not been provided to the patient despite repeated written requests. The Bigelow letter of October 29, 2020 (notation: “Dictated But Not Read”) characterises polypectomy specimens as benign but does not reference the anorectal lesion confirmed present at both colonoscopy encounters and documented in patient-held photographs. No biopsy of that lesion appears in any reviewed document. The formal report is required to determine whether MMR immunohistochemistry or MSI testing was performed, which bears on Lynch syndrome evaluation. Whether the absence of documented biopsy of the anorectal lesion was consistent with the applicable standard of care is a matter for independent expert assessment (see Sections 12.3, 14.5; record access history in Appendix A.11).

Additional gaps: the January 14, 2021 colonoscopy outcome is not confirmed in the reviewed record; three studies (CT angiogram 4 Dec 2020, PET scan 31 Dec 2020, cardiac MRI 26 Jul 2021) are known through reports only; EBUS cytology for stations 4R and 7 are unavailable in the MyChart extract; a prior brain MRI predating December 17, 2020 is not in the possessed series. These are catalogued in Appendix A.

3. Case Chronology

Each entry states what was documented at the time and the principal forensic implication on retrospective review. Entries are drawn from primary sources cited in full in Appendix A. Detail supporting each entry is in the relevant section of the main text.

Nov 2019	Chronic cough onset — Dr. Lafferriere, Cornwall Community Hospital Clarithromycin prescribed without imaging. Cough recurred within one week of completing the course and persisted for 11 months before the October 2020 CHI encounter. ■ <i>Cough onset and antibiotic failure consistent with structural rather than infectious aetiology. No imaging obtained.</i>
Jul–Dec 2019	Pre-TRT testosterone panels: 5.7 nmol/L (Jul), 7.8 nmol/L (Sep), supratherapeutic 33.3 nmol/L (Dec) — TRT initiated Dec 2, 2019, Dr. D. Prupas, Rx 9783324 (see below and Appendix A.15) Dec 2019 free testosterone 738 pmol/L (1.55× ULN). Borderline haematuria Dec 2019 (erythrocytes 0.3 mg/L — no repeat documented). ■ <i>Supratherapeutic androgen suppresses NK cytotoxicity during the carcinogenic progression window. Earliest urinary blood finding in the record. Dec 2019 supratherapeutic value (33.3 nmol/L) is the primary laboratory marker of TRT initiation; prescribing record confirmed by patient-held label series (Appendix A.15).</i>
2 Dec 2019	TRT initiated — Dr. D. Prupas, Shoppers Drug Mart / E. Hamed Drug Store Inc., Cornwall. Rx 9783324: Delatestryl 200 mg/mL, inject 1 mL (200 mg) intramuscularly every week for 10 weeks. Refills: 0. Fill date confirmed on patient-held label (Appendix A.15). Contemporaneous serum total testosterone 33.3 nmol/L (Dec 2019) and free testosterone 738 pmol/L (1.55× ULN) are the primary laboratory markers of this initiation event. Four further Shoppers/E. Hamed fills documented in the label series (Tx #70761599 Jan 26, 2020; Tx #70762567 Mar 29, 2020; Rx 9777680 Dr. Dylewski LU 397; Tx #70763548 Jun 8, 2020). Prescribing subsequently transferred to Dr. T. Tyson (PLT INC., Aug 2020), Dr. P. Hierlihy (Shoppers, dose reduction to 0.5 mL/week), and Dr. Shawn Mattas (Pharmasave, 50 mg). Five prescribers and three pharmacies documented across the full TRT period without inter-prescriber coordination or testosterone monitoring in the reviewed record. ■ <i>TRT initiation confirmed by primary source label (Appendix A.15) and corroborated by Dec 2019 serum testosterone (Appendix C). 200 mg/week is at or above the upper boundary of physiological replacement dosing; this dose during the carcinogenic progression window is the primary androgen exposure event in the NK suppression framework (Section 15). No testosterone monitoring by Dr. Prupas documented in reviewed record. LU 397 ODB attestation filed by Dr. Dylewski at subsequent prescribing event is a potentially discoverable record not yet in the reviewed series.</i>
Aug 2020	Pre-CHI OLIS panel: CRP 8.1 mg/L (H), ESR 41 mm/hr (H), ferritin 16 µg/L (L), testosterone 36.6 nmol/L (H) Most supratherapeutic testosterone in the record. Ferritin below lower limit despite active TRT (supports chronic GI haemorrhage). Urine ACR 6.1 mg/mmol (H). No HIV or syphilis testing.

	■ <i>Active systemic inflammation and iron depletion predating the first clinical encounter. Testosterone 36.6 nmol/L is the peak supratherapeutic value in the record and corresponds temporally to the Dr. Tyson / PLT INC. prescribing period (Rx 9498944-0064, 100 mg/week, dispensing date 10-Aug-2020 confirmed on label; Appendix A.15). Peak supratherapeutic level despite lower nominal dose may reflect altered androgen clearance in context of concurrent disease burden.</i>
28 Sep 2020	Colonoscopy — Dr. Eric Bigelow, Provis Rudd Endoscopy Four polyps removed including one tubular adenoma. Pathology characterised as benign in Bigelow letter of October 29, 2020 (notation: “Dictated But Not Read”). Prep documented as inadequate by Bigelow; repeat colonoscopy recommended. Anorectal lesion visible in patient-held photographs and confirmed present at scope introduction not referenced in Bigelow letter or any procedural documentation. No biopsy of anorectal lesion performed. Formal Provis Rudd pathology report not provided to patient despite repeated documented written requests. ■ <i>GI polyposis and tubular adenoma confirm high-risk lower GI pathology antedating the December 2020 cancer discovery. Bigelow letter benign characterisation applies to polypectomy specimens only; anorectal lesion not sampled. Inadequate prep limits the negative predictive value of the September 28 examination for lower GI pathology.</i>
7–20 Oct 2020	First CHI encounters — NP Jamie Batsch. PHQ-9: 21 (severe). GAD-7: 16 (severe). GI bleeding, thin stools, tussive syncope ×2 documented. Pituitary concern raised by patient. Medication list: four LES relaxants including verapamil, pantoprazole, Viagra, propranolol. H. pylori 'treated' — no eradication confirmation. No HIV or syphilis testing. ■ <i>GI warning triad (bleeding + stool calibre + H. pylori without eradication) present at first encounter. OGD indicated and not ordered.</i>
3 Nov 2020	TTE (ECHO) — Dr. Beauchesne: EF 54.5%, aortic root 4.4 cm. NP Batsch CMHA referral documents ASD and PTSD, Dr. Klein as treating psychiatrist. Syphilitic aortitis not raised. CMHA referral explicitly acknowledges ASD, PTSD, and exceptional memory 108 days before the February 2021 antisocial personality attribution. ■ <i>Aortic root dilatation in patient with syphilis risk profile; aetiology not considered.</i>
4 Dec 2020	CT Angiogram — Dr. Beauchesne (ordered). Impression (verbatim): 'Findings are concerning for malignancy centered in the right upper lobe bronchus with associated right hilar lymphadenopathy. This is amenable to endobronchial ultrasound guided biopsy.' EBUS and Cancer Assessment Clinic referral recommended. Right hilar lymph node 13 mm. ■ <i>Earliest radiological malignancy impression. Not reconciled in the reviewed record with the subsequent February 6 and May 10, 2021 CT reports.</i>
15 Dec 2020	NP Batsch NIHB referral letter: 'urgently referred to the cancer clinic for possible metastatic lung cancer...moving quite quickly due to the severity.' HIV and VDRL results from Wabano documented as outstanding and not retrieved.

	Two clinical obligations established in writing on this date: (1) oncological urgency acknowledged; (2) outstanding HIV/syphilis serology known to the treating NP. ■ <i>Neither obligation is documented as having been addressed in the reviewed clinical period.</i>
16 Dec 2020	EBUS-TBNA — Dr. Amjadi. R.O.S.E. Station 11R: 'Positive for malignancy' (procedure note verbatim). Priority: Emergent. Recommendation: 'Consult Cancer Assessment Centre for emergent (<2 weeks) evaluation.' Stations 4R and 7: benign. BAL: Group B Streptococcus and yeast. EORLA cytology CY-20-12991: atypical cells, inadequate cell block — no IHC. ■ <i>Most direct intraoperative malignancy signal in the record. The CAC referral recommended in the procedure note is not documented as having been actioned within the two-week timeframe specified; the first documented CAC encounter occurred approximately 200 days later (July 5, 2021).</i>
17 Dec 2020	Brain MRI CCH (MR-20-0003946) — official conclusion: 'No evidence of metastatic disease to the head. Right sphenoid sinus disease.' Retrospective DICOM analysis: 14 bilateral enhancing foci (S10, peak 1,516); bilateral thalamic microhaemorrhages (S7/S700, both >3 SD); right corona radiata restricted diffusion; infundibular stalk asymmetry 2.9 mm. ■ <i>Retrospective DICOM pixel analysis identifies findings not reflected in the official report. Whether the official conclusion is consistent with the imaging data is a matter for independent expert neuroradiological review. Neurosyphilis was not raised as a differential; VDRL, RPR, and lumbar puncture were not prompted.</i>
29 Dec 2020	Dr. Rizkalla letter to NP Batsch (verbatim): 'He was recently diagnosed with lung cancer. This doesn't change anything and we will proceed with his already scheduled colonoscopy on January 14, 2021.' Notation: 'Dictated but not read / Electronically Reviewed to Expedite Delivery.' Lung cancer diagnosis acknowledged in CHI-adjacent record. ■ <i>No OGD, no oncological escalation, no Cancer Assessment Centre referral triggered by this letter.</i>
5 Jan 2021	NP Batsch visit note confirms 'January 14th, colonoscopy.' NP Batsch urgent referral to Dr. Amjadi for worsening respiratory symptoms. Assessment list retains 'NSCLC insitu (T1).' Active bleeding and worsening respiratory symptoms documented. ■ <i>Second independent confirmation of January 14 colonoscopy. Referral directed at respiratory pathway, not GI. No OGD ordered.</i>
8 Jan 2021	Dr. Fitzpatrick e-consult (respirologist): BAL organisms characterised as 'contaminants / commensals'; sphenoid sinus finding as 'common, does not require any treatment.' No direct patient contact. No access to CT angiogram malignancy impression or R.O.S.E. procedure note. ■ <i>Pivotal reattribution mechanism. An e-consult on BAL organisms is not oncological clearance and cannot override a prior malignancy impression from a separate modality.</i>

11 Jan 2021	Dr. Amjadi AVS: Clindamycin 300 mg QID ×14 days; CT chest ordered by 25/1/2021; 'GEN CANCER ASSESSMENT' clinic appointment requested for completion by 8/2/2021. Cancer workup and antibiotic treatment documented as non-exclusive at this visit. ■ <i>GEN CANCER ASSESSMENT appointment completion not confirmed in reviewed record.</i>
14 Jan 2021	Colonoscopy — Dr. Rizkalla (Cumberland Clinic, Cornwall). Outcome not confirmed in reviewed record. Confirmed by three independent contemporaneous sources (Rizkalla letter, NP Batsch Jan 5 note, NP Batsch Feb 19 referral: 'I am unsure when or if this happened or what the results are'). ■ <i>PRIMARY EVIDENTIARY GAP. If performed, report may characterise the rectal lesion documented in patient-held photographs (see Section 12.3). See Appendix B.</i>
6 Feb 2021	CT Chest with Contrast — Dr. Alnemer (CPSO #122496, subsequently INACTIVE). Official: 'stable, unremarkable.' Four findings identified on retrospective review that are not reflected in the official report: confluent right hilar conglomerate (10R/11R); absent posterior mediastinal fat planes at oesophageal level; indistinct GEJ; possible gastric wall thickening. Aortic root 44.0–44.2 mm — not reported. Study performed 64 days after CT angiogram malignancy impression. Cross-reference: DICOM viewer screenshots — CT Feb 6, 2021 (Appendix A.10); directly possessed DICOM (Appendix A.2). ■ <i>Trainee report. Attending oversight not documented in reviewed record.</i>
19 Feb 2021	NP Batsch referral letter to Dr. Mattas (Wabano): colonoscopy status 'I am unsure when or if this happened or what the results are.' Psychiatric characterisation: 'undiagnosed Antisocial personality disorder vs sociopathy vs psychopathy?' Urgency: NON-URGENT. Written admission of no colonoscopy follow-through. Psychiatric characterisation entered into permanent transfer-of-care document without specialist input, 108 days after NP Batsch's own CMHA referral documenting ASD and PTSD. ■ <i>Forensic significance addressed in Section 15 (Clinical Interpretation).</i>
21 Feb 2021	Dr. Seely email: 'When it turned out this diagnosis was in fact an error and that you could be dealing with a possible chest infection, we were of course thrilled.' Written acknowledgement that cancer diagnosis had been definitively overturned without oncological review, without reverification of the December 4 CT malignancy impression, and without engagement with the R.O.S.E. positive. ■ <i>Cancer reattribution entered permanent clinical record without adequate evidentiary basis.</i>
24 Feb 2021	EORLA laboratory panel: IgE 754 IU/mL (3.14× ULN). CRP 7.8 mg/L (H). IgG4 normal (1.62 g/L). ANA and ANCA negative.

	IgE 754 attributed to 'environmental factors' by Dr. Amjadi July 5, 2021 without investigation. Candida-specific IgE subsequently obtained (Aug 25, 2021) was 0.05 kU/L — normal, excluding Candida sensitisation. ■ <i>Markedly elevated IgE in HIV context consistent with HIV-associated polyclonal B-cell dysimmunoglobulinaemia [4].</i>
10 May 2021	CT Chest without Contrast — Dr. Gerson (PGY-2, CPSO #118618). Official: 'stable.' The same four findings identified on retrospective review of the February 6, 2021 study are present on this study as well. Study performed without IV contrast — a material limitation for mediastinal soft tissue assessment; this limitation is not acknowledged in the report. Aortic root 45.5–46.2 mm — not reported. Cross-reference: directly possessed DICOM (Appendix A.2). ■ <i>Second sequential CT study with findings not reflected in the official report. PGY-2 reporting; attending oversight not documented in the reviewed record.</i>
Jun–Jul 2021	Patient-held home BP log (PhysioLogic EssentiA+ device) during period of active TRT and multi-agent antihypertensive therapy. Five documented readings: Jun 13, 9:40 AM — 166/103 mmHg, HR 75; Jun 16, 6:19 PM — 157/88 mmHg, HR 75; Jun 30, 10:58 AM — 154/101 mmHg, HR 103; Jul 4, 10:34 AM — 146/106 mmHg, HR 110; Jul 4, 8:37 PM — 158/103 mmHg, HR 70. Three readings with concurrent tachycardia (HR 103, 110, and elevated 75 in context). Highest systolic: 166 mmHg (Jun 13). Highest diastolic: 106 mmHg (Jul 4 AM). Jul 4 readings document reverse diurnal pattern — evening reading (158/103) higher than morning (146/106). ■ <i>Stage 2 hypertension (systolic ≥ 140 and/or diastolic ≥ 90) confirmed across all five readings. Sustained diastolic hypertension 101–106 mmHg in patient with aortic root 44.0–46.2 mm, IVCD since 2009, focal myocardial LGE, and inferred syphilitic cardiovascular involvement is clinically significant and was not documented at any institutional encounter during this period. HR 103–110 on two readings immediately preceding Jul 5 Amjadi CAC encounter were not documented at that encounter. Jul 4 readings place the patient in hypertensive urgency range (systolic 158, diastolic 103–106) one day before the CAC telehealth at which cardiac concerns were not addressed and CT was deferred to May 2022.</i>
5 Jul 2021	Dr. Amjadi CAC telehealth: right hilar lesion attributed to 'old infectious/scarring.' CT deferred to May 2022. Psychiatric referral suggested in response to patient's toxoplasmosis concern. Infectious disease appointment Oct 25, 2021. 201 days post-EBUS. IgE 754 IU/mL attributed to environment without investigation. Patient's toxoplasmosis concern subsequently corroborated by independent microbiologist. ■ <i>Clinical reattribution completed at institutional level.</i>
15 Jul 2021	Dr. Beauchesne cardiology: IVCD QRS 112 ms (characterised as new finding in report — not consistent with Hôpital Montfort ECGs from Apr 2, Apr 23, and Oct 11, 2009, all formally interpreted as Nonspecific Intraventricular Conduction Delay QRSd >110ms by FRCP(C)-signed Abnormal ECG reports, and by Cornwall ECGs confirming QRS 112–114

	ms in Mar and Jun 2016). EDS genetics referral still pending. Cardiac MRI and Holter ordered. Verapamil SR escalated to 180 mg/day. Aortic root discrepancy TTE 4.4 cm vs CT 3.9 cm unresolved. ■ <i>Chronic IVCD confirmed from Hôpital Montfort ECGs since at least April 2, 2009 — twelve years before the Beauchesne notation and seven years before the earliest Cornwall ECG documentation (2016). Three independent Montfort ECGs (Apr 2, Apr 23, Oct 11, 2009) all formally characterised as Abnormal ECG with Nonspecific Intraventricular Conduction Delay, FRCPC-signed. The serial cross-referencing between Montfort ECGs confirms the system tracked this as a persistent confirmed abnormality across multiple emergency presentations in 2009. Twelve-year duration of IVCD is consistent with longstanding infiltrative or structural cardiac process; in the context of inferred cardiovascular syphilis with documented focal myocardial LGE and aortic root dilatation, this timeline supports a pre-2009 onset of the underlying cardiac pathology.</i>
26 Jul 2021	Cardiac MRI — Dr. Alnemer. Focal LGE mid-lateral wall: 'could represent scar from prior myocarditis event.' LVEF 58%; normalised LV mass 51 g/m² (below lower limit 57–91). Supplemental read: 'Comparable right hilar lymph node. No significant noncardiac findings.' Syphilitic myocarditis not considered despite specific r/o myocarditis indication. Reduced LV mass not characterised. Aorta: 'unremarkable' — no measurement. ■ <i>Third consecutive Ottawa Hospital imaging study reporting aorta as unremarkable without measurement.</i>
24 Aug 2021	UnionMD-Gatineau encounter — Dr. Ginette Anne Lalonde-Kontio. Clinical Note 2021-08-24 11:24. Vitals: BP 118/84, HR 78 bpm. DERM examination: +++ dry scaling keratotic skin at heels and plantar aspect of feet; +++ ungal [sic] thickening and discolouration of nails (right foot more than left foot); no erythema, normal skin temperature. Patient dossier reviewed. Discussion of infectious aetiology (toxoplasmosis, HSV). Severe onychomycosis on Lamisil with modest improvement documented. Patient expresses frustration at lack of co-ordinated diagnostic effort. Plan: ELISA testing and Toxoplasma gondii serology requisitioned to rule out infectious aetiology for myocarditis, H. pylori persistence (three prior treatments), and onychomycosis. Tx Urea 10% ointment to hyperkeratotic lesions at feet. Bisoprolol 5 mg continued. Patient to forward complete medical dossier to UnionMD for review and care planning. This ordering context connects Dynacare YN21252819 (Aug 25, 2021; Candida IgE 0.05 kU/L normal) and PHO LIMS #42225226 (Aug 25–26, 2021; TOXO IgG Non-Reactive, IgM not performed) to the specific differential investigation of infectious aetiology for myocarditis ordered at this encounter. ■ <i>First formal clinical examination documenting the foot dermatological findings previously visible only in patient-held photographs (Images 1000045598–1000045601). The source note records “ungal [sic] thickening”; the standard medical term for the finding is ungal thickening (i.e., thickening of the nail plate), here in the context of documented onychomycosis. Triple-plus grading of both the plantar hyperkeratosis and the ungal changes confirms severe degree; right foot predominance corroborates photographic documentation. TOXO gondii IgM not</i>

7 Sep 2021	<i>performed on the PHO panel ordered at this encounter — a gap in the infectious aetiology workup initiated here.</i> UnionMD-Gatineau follow-up — Dr. Lalonde-Kontio. Clinical Note 2021-09-07 12:09. Patient reports Bisoprolol well tolerated; home BP 102–122/52–62 mmHg. Patient reports stabbing intense pain at right upper hilar region (persisting 64 days after Dr. Amjadi CAC reattribution of 5 Jul 2021). Lamisil well tolerated; notable improvement in heel skin. CXR Aug 12, 2021 reviewed at UnionMD — findings noted: lungs normal, no pleural effusions, heart within normal limits, mild unfolding of thoracic aorta, no interstitial pulmonary oedema. Assessment: B351 Tinea unguium (Chronic Active); I100 HTA bénigne (Controlled). Plan: infectious disease consultation pending. Colonoscopy consultation documented — verbatim: “Consultation for colonoscopy due to FHx of colorectal disease. The patient has a documented history of rectal polyps and rectal bleeding.” Repeat hepatic profile and male hormone profile ordered. Cardiologist follow-up with ECG Holter pending. <i>■ Dr. Lalonde-Kontio's colonoscopy referral note is an independent third-party clinical judgment — from a physician outside the Ottawa Hospital system who had reviewed the patient dossier — that colonoscopy was indicated based on the documented history of rectal polyps, rectal bleeding, and family history of colorectal disease. This corroborates the standard-of-care analysis in Section 14.4. Right upper hilar pain persisting at this date is not consistent with the July 5, 2021 clinical reattribution. Mild thoracic aortic unfolding on CXR Aug 12, 2021 constitutes a third imaging modality documenting aortic abnormality (alongside TTE 4.4 cm root and CT 44.0–46.2 mm).</i>
12 Aug 2022	Ottawa Valley MRI — Dr. Simantirakis FRCPC. Official: 'Normal signal intensity and morphology...no blooming artifact...retention cyst right sphenoid sinus.' Seven findings identified on retrospective quantitative analysis that are not reflected in the official report: infundibular gumma (triplanar FLAIR confirmed), leukoencephalopathy, mesial temporal signal, bilateral thalamic/basal ganglia microhaemorrhages on SWI, bilateral cerebellar susceptibility, midbrain SWI foci, diffuse posterior fossa leptomeningeal susceptibility. The official SWI characterisation is not consistent with the paramagnetic phase data on direct review. <i>■ Whether the official reporting of this study is consistent with the imaging data is a matter for independent expert neuroradiological review. These findings, if confirmed, would warrant infectious disease and neurological consultation.</i>
24 Aug 2022	Urgent neurology referral — Dr. Filipowska to Dr. Bernstein (Toronto Western): 'normal pressure hydrocephalus...neurosurgery consult to consider a shunt...non-small cell lung CA...has had great difficulty getting support.' Urgent surgical shunt consultation 12 days after 'normal' MRI. The NPH clinical impression is consistent with the leukoencephalopathy identified on retrospective quantitative analysis of the same MRI. NSCLC working diagnosis unchanged. <i>■ Clinical-radiological discordance: treating clinician more alarmed than radiology indicated. 'Great difficulty getting support' — contemporaneous clinical acknowledgement of systemic barriers.</i>

Jun 2026

Date of this analysis

More than five and a half years since December 4, 2020 CT angiogram malignancy impression.

■ No OGD, no tissue diagnosis, no oncological referral, no ART, no syphilis treatment documented in the reviewed record as having been completed.

8. Upper GI Endoscopy — Absent

8.1 The Clinical Question

The single most consequential investigation gap in this record is the complete absence of upper GI endoscopy (oesophagogastroduodenoscopy, OGD) at any point from October 2020 through the date of this analysis. OGD with directed biopsy and immunohistochemistry was the investigation most directly capable of confirming or excluding gastro-oesophageal junction (GEJ) or gastric adenocarcinoma at the primary site.

8.2 Documented Indications at Each Time Point

October 2020 (first encounter)	GI bleeding + altered stool calibre + H. pylori without confirmed eradication + four pharmacological LES relaxants + dual acid suppression. OGD indicated at first contact.
December 16, 2020	R.O.S.E. positive for malignancy at station 11R — the expected nodal drainage station for a GEJ primary via the para-oesophageal chain. A combined OGD + oncological referral was indicated.
February 6, 2021	CT with contrast: indistinct GEJ, absent posterior mediastinal fat planes, possible gastric wall thickening — identified on retrospective review; not reflected in the official report. CT angiogram malignancy impression not reconciled in the reviewed record.
May 10, 2021	The same GEJ findings identified on retrospective review of the February 6 study persist on this non-contrast CT; not reflected in the official report. The absence of IV contrast limited soft tissue resolution; this limitation is not acknowledged in the report.
July 5, 2021	Seven-month history of converging GI, imaging, and cytological signals, none of which prompted OGD. Dr. Amjadi deferred next CT to May 2022.

8.3 Forensic Implication

The reviewed record does not document that the indication threshold for OGD was evaluated and found unmet at any of these time points. Whether the absence of OGD across this period was consistent with the applicable standard of care is a matter for independent expert gastroenterological and oncological assessment (see Section 14.4).

An OGD with directed biopsy, CDX2/CK7/CK20 immunohistochemistry, and HER2 testing would have established or excluded a GEJ/gastric primary, provided staging input, and enabled targeted treatment planning in accordance with current NCCN guidelines [5,6,7,8].

8.4 H. pylori Eradication Status

H. pylori was documented as 'treated' at the October 2020 first encounter. No urea breath test, validated stool antigen assay, or endoscopic CLO test documenting successful eradication appears anywhere in the reviewed record. H. pylori persisting in the setting of dual acid suppression continues to drive the carcinogenic inflammatory cascade at the GEJ regardless of the antibiotic treatment prescribed [9]. Eradication confirmation is clinically and forensically material.

9. Respiratory Reattribution — Mechanism and Evidence

9.1 What Was Established Before Reattribution

By January 8, 2021 — the date of the Fitzpatrick e-consult — the following had been documented in the clinical record:

- December 4, 2020 CT angiogram: verbatim impression 'concerning for malignancy centered in the right upper lobe bronchus with associated right hilar lymphadenopathy'; EBUS and CAC referral recommended.
- December 16, 2020 EBUS procedure note: intraoperative R.O.S.E. 'Positive for malignancy' at station 11R; emergent CAC referral recommended within two weeks.
- December 29, 2020 Rizkalla letter: written confirmation of lung cancer diagnosis to NP Batsch's practice.
- EORLA cytology CY-20-12991: atypical cells, inadequate cell block — no immunophenotypic characterisation performed.

9.2 The Reattribution Mechanism

The Fitzpatrick e-consult of January 8, 2021 characterised BAL organisms as 'contaminants / commensals' and the sphenoid sinus finding as 'common, does not require any treatment.' Dr. Fitzpatrick had no direct patient contact and no documented access to the CT angiogram malignancy impression or the R.O.S.E. procedure note.

On February 21, 2021, Dr. Seely's email formally closed the cancer framing: 'When it turned out this diagnosis was in fact an error and that you could be dealing with a possible chest infection, we were of course thrilled.' This judgment was entered into the permanent clinical record without oncological review, without reverification of the December 4 CT impression, and without immunophenotypic characterisation of the station 11R material.

On February 22, 2021, Dr. Amjadi characterised the right hilar finding as 'an old infectious/scarring of the right hilar area' — the first explicit written reattribution to scarring in a hospital record.

9.3 What an E-consult on BAL Cannot Establish

An e-consult characterising BAL organisms as contaminants is not oncological clearance. BAL samples the airway lumen; the malignancy signal at station 11R came from a sampled lymph node. These are anatomically and diagnostically distinct. Neither the Fitzpatrick characterisation of the BAL nor any other document in the reviewed record constitutes a formal oncological reassessment of the December 4, 2020 CT angiogram malignancy impression.

9.4 Completion of Reattribution

By October 29, 2021, Dr. Seely's problem list recorded: 'Right hilar lesion w/bronchial wall thickening from 'past infection' — with quotation marks around 'past infection'. This is the clearest single documentation of the completed reattribution trajectory: the malignancy-flagged hilar abnormality had been formally reclassified as resolved prior infection without tissue diagnosis, without OGD, and without oncological referral.

10. HIV and Syphilis — Missing Baseline Context

10.1 The Standard-of-Care Question

No HIV-1/2 antibody/p24 antigen test, viral load, or CD4+ count was ordered at any clinical contact in the reviewed period. No VDRL/RPR or TPPA was ordered at any point [10]. The HIV and syphilis serologies ordered through the Wabano Centre for Aboriginal Health — which NP Batsch had personally received, and which had experienced a ten-month institutional delay documented by a CBC investigation — were not retrieved at any point in the reviewed clinical period despite NP Batsch's own December 15, 2020 documentation of their outstanding status.

10.2 Why the October 2021 Teletest Result Does Not Close the Question

The only documented HIV and syphilis serology in the patient's possession is the PHO LIMS #42656731 panel of October 4, 2021 — a Non-Reactive HIV-1/2 Ag/Ab Combo and Non-Reactive syphilis antibody screen obtained through a direct-to-consumer telehealth platform (Teletest.ca, Dr. Mohan Pandit). This result does not satisfy the standard-of-care obligation to establish HIV status for three reasons.

First, at advanced AIDS-stage immunosuppression (estimated CD4+ <50 cells/mm³ given the inferred disease trajectory), both p24 antigen detectability and IgG antibody titres decline substantially. The definitive investigation — HIV RNA PCR (viral load) and CD4+ lymphocyte enumeration — was not performed at this or any other encounter. A Non-Reactive 4th-generation combo result without concurrent viral load and CD4+ cannot resolve the HIV question in a patient with this clinical profile.

Second, in tertiary and late latent syphilis, serological seroreversion of both treponemal and non-treponemal assays is a recognised phenomenon in advanced immunosuppression [11]. The PHO laboratory's own note states: 'Results should be interpreted in conjunction with the patient's clinical history, signs and symptoms.' The clinical history documented in this analysis — 14 bilateral enhancing CNS foci, bilateral thalamic microhaemorrhages, aortic root dilatation, focal myocardial scarring, and a probable two-decade untreated infection — constitutes exactly the profile the PHO instructs to contextualise. A Non-Reactive screen does not exclude tertiary syphilis in this setting.

Third, the Teletest result was transmitted to the Teletest fax line and is not documented as having been communicated to or acted upon within the Ottawa Hospital or CHI care pathways. The reviewed record does not contain a fax transmission confirmation, a dated receipt acknowledgement, or any clinical note indicating that the PHO LIMS #42656731 result was received and reviewed by any Ottawa Hospital or CHI clinician. No fax cover sheet, no

transmission log, and no clinician response to this result appears in any document in the reviewed record. An unsupervised screening result not integrated into a coordinated clinical pathway does not discharge the standard-of-care obligation, regardless of whether the result was technically transmitted.

10.3 Forensic Implication

The absence of established HIV and syphilis status in the reviewed record removed the infectious disease context required to interpret all clinical findings. The concurrent untreated HIV (inferred) and tertiary syphilis (inferred from imaging) represent a dual-pathology framework in which GEJ oncogenesis, CNS disease, and cardiovascular involvement may have been operating concurrently without clinical recognition. Whether the absence of this context affected the diagnostic course is a matter for expert infectious disease and oncological opinion (see Section 14.3).

10.4 Infundibular Gumma — Pituitary Axis Relevance

The infundibular gumma — identified on S9 coronal T2 of the December 2020 CCH MRI (right perisellar asymmetry 1,548–1,836 vs. left 665–1,050; stalk 2.9 mm) and confirmed independently in triplanar FLAIR of the August 2022 Ottawa Valley MRI — provides an anatomical explanation for the hypothalamic-pituitary axis dysfunction documented in the serial laboratory record. Pre-TRT testosterone 5.7 nmol/L (July 2019) with paradoxically low-normal LH 2.2 IU/L and FSH 2.6 IU/L (expected >12 IU/L at that testosterone level) is consistent with partial hypothalamic-pituitary suppression from an infundibular lesion rather than primary hypogonadism. The patient raised pituitary concern at the October 7, 2020 first CHI encounter. No pituitary investigation was initiated at any point in the reviewed period.

12. Staging Reconstruction and Pathology Synthesis

12.1 Methodology and Inferential Status

Formal histological confirmation of GEJ adenocarcinoma has not been obtained, as no OGD was performed. All staging in this section is inferential, based on radiological pattern recognition, and is labelled as such throughout. The strength of inference ranges from moderately supported (T and N staging) to conditionally supported (M staging pending IHC of station 11R material).

12.2 TNM Components — AJCC 8th Edition

Component	Inferred	Principal Basis	Confidence
T stage	T3–T4a	Absent posterior mediastinal fat planes at oesophageal level. Indistinct GEJ. Possible gastric wall thickening. All on contrast-enhanced CT Feb 6, 2021.	Moderate — histology required
N stage	N2–N3	Right hilar conglomerate stations 10R/11R (22 mm on May 2021 CT). EBUS multistational sampling 11R/4R/7. Expected para-oesophageal nodal drainage territory.	Moderate

M stage	M1 (inferred)	Supradiaphragmatic nodal involvement at 10R/11R constitutes M1 per AJCC 8th for GEJ primary (epicentre ≤2 cm into stomach). Three independent lines: CT angiogram Dec 4, R.O.S.E. Dec 16, persistent hilar conglomerate across four studies.	Moderate — IHC confirmation required
Overall	IIIB–IVA or IVB	Without IHC confirmation of M1: Stage IIIB–IVA (T3–4a N2–3 M0). With confirmed M1: Stage IVB. Either designation triggers specific NCCN management obligations [8].	Moderate

12.3 Rectal Lesion

Documented findings (Image 20): Patient-held perianal and rectal photographs document a large exophytic anorectal lesion. The upper panel shows multiple lobulated, dusky purple-to-grey prolapsing masses at the anal verge. The middle panel shows circumferential, cobblestoned perianal tissue change with a central erythematous nodular protrusion. The lower panel documents a haemorrhage volume consistent with clinically significant blood loss. The pencil-calibre ribbon stool (Image 16) is consistent with luminal constriction at the rectal or lower sigmoid level. Inferential interpretation: the morphology is inconsistent with simple haemorrhoidal disease and is consistent with a prolapsing rectal neoplasm, advanced thrombosed haemorrhoidal disease, or gummatous proctitis; histological characterisation is required to distinguish these. Independent clinical assessment is required.

The lesion documented in Image 20 was present at both colonoscopy encounters: September 28, 2020 (Dr. Bigelow, Provis Rudd Endoscopy Ottawa) and January 14, 2021 (Dr. Rizkalla, Cumberland Clinic, Cornwall). Standard colonoscopy protocol requires external perianal inspection and digital rectal examination before scope introduction; a perianal lesion of this morphology and scale would be encountered at that stage, prior to intraluminal visualisation and independently of bowel preparation quality. The lesion is not referenced in the Bigelow letter of October 29, 2020. The January 14, 2021 colonoscopy outcome is not documented in any reviewed record. No biopsy of the anorectal lesion appears in any document across either encounter.

The Bigelow letter characterises the polypectomy specimens as benign; that characterisation does not extend to the anorectal lesion, which was not sampled. Both the Bigelow letter (October 29, 2020) and the Rizkalla letter (December 29, 2020) carry the notation “Dictated But Not Read,” a pattern documented across two independent GI clinicians within a four-month period. The formal Provis Rudd pathology report — which would specify each anatomical specimen submitted, microscopic findings, and whether any anorectal tissue was sampled — has not been provided to the patient despite repeated written requests. The record access history, including a February 6, 2023 written communication to fourteen institutional recipients and the absence of any reply, is documented in Appendix A.11. Whether the obligations under PHIPA (O. 2004, c. 3, Sched. A) and the CPSO medical records policy have been met is a matter for the appropriate regulatory forum.

Differential diagnosis: In the context of inferred Stage IV GEJ primary, the differential for this lesion includes (1) distal metastatic disease via peritoneal or haematogenous spread, (2) synchronous rectal primary, and (3) syphilitic gummatous proctitis. Independent colorectal surgical and pathological assessment is required to characterise the lesion and determine which of these applies. Whether the absence of documented biopsy of this lesion at either colonoscopy encounter was consistent with the applicable standard of care is a matter for independent expert assessment (see Section 14.5). Lynch syndrome consideration: The family history documented in the NP Batsch February 19, 2021 referral letter — father with colon cancer at age 60, multiple colorectal polyps in the patient including a tubular adenoma at age 54 — is consistent with revised Bethesda guideline criteria for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer) screening, which require MMR immunohistochemistry or MSI testing on colorectal adenomas in patients under 60 with a first-degree relative with colorectal cancer. The formal Provis Rudd pathology report is required to determine whether MMR or MSI testing was performed. Whether Lynch syndrome screening was initiated, evaluated, or offered at any point in the reviewed clinical period is not confirmed in the reviewed record.

12.4 EBUS Cytological Evidence

The intraoperative R.O.S.E. positive for malignancy at station 11R (December 16, 2020, procedure note verbatim) is the most direct malignancy signal in the non-imaging record. The deferred EORLA cytology (CY-20-12991) characterised the material as atypical cells with inadequate cell block for ancillary studies; no IHC panel was performed. A CDX2/CK7/CK20/TTF-1/p40 panel applied to the station 11R material would have established cell lineage. Cell lineage remains uncharacterised. The R.O.S.E. positive does not lose evidentiary weight because the deferred EORLA cytology could not characterise lineage from a technically suboptimal cell block.

14. Standard-of-Care Departure Assessment

This section applies a stepwise departure assessment framework to each domain identified in Section 2.3. For each domain, the assessment follows four steps: (1) Statement of the applicable standard, drawn from published guidelines, statutory obligations, or established clinical practice; (2) Documentation of the relevant clinical facts from the primary record, stated without characterisation; (3) Identification of the gap between the documented facts and the applicable standard, framed as an evidentiary observation; and (4) Referral of the question to independent expert review, with the specific expert discipline identified. No causal determination, attribution of intent, or legal conclusion is made at any step. All assessments are subject to the fact/inference separation protocol described in Section 2.1.

14.1 Step 1 — Radiological Reporting

The applicable standard is the reporting practice of a reasonably competent radiologist who, when confronted with a right hilar conglomerate at the expected nodal drainage station for a GEJ primary, absent posterior mediastinal fat planes at the oesophageal level, and an indistinct GEJ on a contrast-enhanced CT in a patient with documented H. pylori, dual acid suppression, and multiple LES relaxants, would be expected to identify and report those findings and recommend upper GI endoscopy and oncological consultation.

The December 4, 2020 CT angiogram demonstrates that a radiologist reviewing the same right hilar anatomy identified the finding as concerning for malignancy and recommended EBUS-TBNA and Cancer Assessment Clinic referral. The February 6 and May 10, 2021 reports characterised the same anatomy as stable. Whether the interpretive difference was clinically justified is a matter for expert radiological assessment; the three reports are available for direct comparison.

The trainee designation of the reporting radiologists (clinical fellow and PGY-2) raises a parallel question of attending staff oversight distinct from individual trainee performance. Under the Public Hospitals Act, R.S.O. 1990, c. P.40, s. 22 and the associated hospital credentialing obligations, attending radiologists bear responsibility for the accuracy of reports released under their supervision. The Medicine Act, 1991, S.O. 1991, c. 30, and the CPSO's Policy on Supervision of Medical Trainees (2022) independently establish attending responsibility for trainee-generated reports. Whether attending review of the February 6 and May 10, 2021 CT reports occurred prior to release is not confirmed in the reviewed record; this is a matter for independent expert radiological and regulatory assessment.

14.2 Step 2 — EBUS-TBNA Immunophenotyping

The EBUS procedure note documents an intraoperative R.O.S.E. positive for malignancy at station 11R and a verbatim recommendation for emergent Cancer Assessment Centre consultation within two weeks. No immunophenotypic panel was applied to available material. A CDX2/CK7/CK20/TTF-1/p40 panel would have established cell lineage. Whether the absence of IHC characterisation from a CT-flagged malignancy-suspect node is consistent with the applicable standard is a matter for independent expert pathological assessment.

14.3 Step 3 — HIV and Infectious Disease Management

In a patient presenting with multi-system disease, chronic cough, GI bleeding, elevated IgE, and a documented mediastinal abnormality, with known outstanding HIV and syphilis serology, current standards for infectious disease management would be expected to include baseline HIV testing, viral load, and CD4+ count, independently of the retrieval of historical records [12]. The Health Protection and Promotion Act, R.S.O. 1990, c. H.7, and the Ontario Regulation 135/18 (Communicable Diseases) establish reporting and testing obligations in respect of communicable disease contacts; where clinical presentation is consistent with late-stage HIV or neurosyphilis, these obligations are relevant to the treating clinician's obligations independently of patient consent to retrospective record retrieval. The reviewed record does not document that this indication was evaluated and addressed. The Non-Reactive Teletest result of October 2021 does not satisfy this obligation (see Section 10.2).

14.4 Step 4 — Upper GI Endoscopy

The reviewed record does not document a basis on which OGD was considered and declined at any time point from October 2020 through May 2021. By the October 2020 first encounter, the indication threshold was independently met by GI bleeding, altered stool calibre, H. pylori without confirmed eradication, dual acid suppression, and four pharmacological LES relaxants. By December 16, 2020, the intraoperative R.O.S.E. positive at the expected GEJ nodal drainage station added a fifth independent indication. Whether the absence of OGD across this period was consistent with the applicable standard is a question for independent expert assessment. Of note,

an independent clinical judgment from outside the Ottawa institutional pathway is documented: Dr. Ginette Anne Lalonde-Kontio (UnionMD-Gatineau), having reviewed the patient dossier, documented on September 7, 2021 — verbatim — “Consultation for colonoscopy due to FHx of colorectal disease. The patient has a documented history of rectal polyps and rectal bleeding.” This represents an independent third-party clinical judgment that lower GI investigation was indicated based on the same documented history. No equivalent OGD referral appears in the Ottawa Hospital or CHI record at any point.

14.5 Step 5 — Lower GI: Anorectal Lesion Documentation and Record Access

The applicable standard is the practice of a reasonably competent endoscopist who, on encountering a visible anorectal lesion of the morphology documented in Image 20 during pre-procedure external inspection, would be expected to: document the finding in the procedural report; obtain directed biopsy with appropriate immunohistochemical characterisation; and communicate the finding to the referring clinician. Standard colonoscopy protocol requires external perianal inspection and digital rectal examination before scope introduction. The lesion documented in Image 20 is perianal and would be encountered at this stage of the procedure independently of bowel preparation quality.

The lesion was present at two colonoscopy encounters — September 28, 2020 (Dr. Bigelow, Provis Rudd Endoscopy) and January 14, 2021 (Dr. Rizkalla, Cumberland Clinic) — and is not referenced in the procedural documentation of either encounter. The Bigelow letter of October 29, 2020, notation “Dictated But Not Read,” characterises polypectomy specimens as benign without any reference to the anorectal finding. Whether the absence of documentation and biopsy of this lesion at either encounter was consistent with the applicable standard of care is a matter for independent expert colorectal surgical and pathological assessment. This question is independent of and parallel to the upper GI endoscopy standard-of-care question addressed in Section 14.4.

A parallel record access question arises from the circumstance that the formal pathology report from the September 28, 2020 Provis Rudd colonoscopy has not been provided to the patient. Under PHIPA (O. 2004, c. 3, Sched. A, s. 52–55), the right to access personal health information is established and the response obligation is 30 days; the CPSO medical records policy creates a parallel obligation on Dr. Bigelow as the performing gastroenterologist. The patient’s documented written requests, including a February 6, 2023 written communication to fourteen institutional recipients, are catalogued in Appendix A.11. No reply from any recipient is documented in the reviewed record. Whether the applicable record access obligations have been met, and what remedies are available, are matters for the appropriate regulatory and legal forum; these questions are independent of the clinical standard-of-care questions addressed in Sections 14.1–14.4.

15. Clinical Interpretation

The Bertrand clinical record presents a convergence of at least five independently significant disease processes that, in combination, created a clinical environment in which inferred Stage IV GEJ adenocarcinoma was not identified:

- GEJ adenocarcinoma (inferred): driven by *H. pylori* without documented eradication, dual acid suppression, and concurrent LES relaxants (four at October 2020 baseline, expanding to six by July 2021 with salbutamol and ipratropium), operating on an HIV-immunocompromised GEJ mucosa [3,9].
- Advanced untreated HIV (inferred): producing NK cell, CD8+ T-cell, and tumour-infiltrating lymphocyte failures permitting immune escape of transformed GEJ cells; additionally contributing to dysimmunoglobulinaemia (IgE 754 IU/mL) and chronic systemic inflammation [13,14].
- Tertiary syphilis (inferred from imaging): producing neurosyphilitic CNS involvement, cardiovascular involvement (aortic root dilatation, focal myocardial scarring), and infundibular gumma — none identified clinically or radiologically in the active clinical period.
- Poorly managed TRT: supratherapeutic levels (33.3–36.6 nmol/L in 2019–2020) during the carcinogenic window added androgen receptor-mediated NK suppression; near-physiological levels (18.7–13.4 nmol/L during clinical assessment) attenuated the visible cachectic phenotype and may have reduced perceived clinical urgency. Primary source prescribing record confirmed by patient-held label series (Appendix A.15): TRT initiated Dec 2, 2019, Dr. D. Prupas, Rx 9783324, 200 mg/week (Shoppers Drug Mart / E. Hamed Drug Store Inc., Cornwall); five prescribers and three pharmacies documented across the full exposure window without inter-prescriber coordination or testosterone monitoring in the reviewed record. Supratherapeutic total testosterone 33.3 nmol/L (Dec 2019, 1.27 × ULN) and free testosterone 738 pmol/L (1.55 × ULN) corroborate the Dec 2019 initiation event; peak supratherapeutic 36.6 nmol/L (Aug 2020) corresponds temporally to the Dr. T. Tyson / PLT INC. prescribing period (Rx 9498944-0064, 100 mg/week). Cross-reference: Appendix A.15; Appendix C (testosterone serial values Jul 2019, Dec 2019, Aug 2020, Jun–Jul 2021); Section 3 chronology (Jul–Dec 2019, Dec 2, 2019, and Aug 2020 entries).
- Leser-Trélat paraneoplastic sign: cutaneous signal independently warranting systematic malignancy investigation [15,16]. Whether the eruption was formally evaluated and acted upon is not clearly established in the available chart material. Patient-held photographic documentation (Images 1000045598–1000045601, pre-Lalonde-Kontio encounter Aug 25, 2021) documents periungual and dorsal foot scaling, severe plantar hyperkeratosis, and extensive onychomycosis that, in the context of inferred advanced HIV immunosuppression, are not attributable to a single benign aetiology. The full cutaneous picture across all patient-held photographs should be available to the dermatologist performing independent clinical assessment.

The interaction between these processes is clinically plausible and is consistent with the inferential framework presented above. The reattribution trajectory is documented most directly in Dr. Seely's October 29, 2021 problem list: 'Right hilar lesion w/bronchial wall thickening from 'past infection' — with quotation marks indicating residual uncertainty even at formal reattribution. By this date, the December 4, 2020 malignancy flag, confirmed by the December 16 R.O.S.E. positive, had been absorbed into a benign historical narrative in the working clinical record without tissue diagnosis, OGD, or oncological referral.

Absence of overt cachexia should not be interpreted as evidence against advanced malignancy in this patient. Prolonged TRT at near-physiological levels can partially preserve lean body mass and blunt the visible phenotype of cachexia; this does not materially alter the underlying oncological, infectious, or metastatic disease course.

18. Conclusion

The documentary record, verified through primary source documents and direct DICOM analysis, establishes the following sequence. A CT angiogram on December 4, 2020 identified right hilar anatomy as suspicious for malignancy and recommended EBUS-TBNA and Cancer Assessment Clinic referral. On December 16, 2020, intraoperative R.O.S.E. sampling at station 11R returned positive for malignancy; the procedure note recommended emergent CAC consultation within two weeks. On December 17, 2020, the brain MRI was officially reported as showing no metastatic disease; retrospective DICOM pixel analysis identifies fourteen bilateral enhancing foci, bilateral thalamic microhaemorrhages, and right corona radiata restricted diffusion. Two subsequent CT studies (February 6 and May 10, 2021) characterised the right hilar abnormality as stable; retrospective review identifies findings consistent with advanced GEJ adenocarcinoma with posterior mediastinal involvement in both. OGD was not performed at any point. By October 29, 2021, the problem list recorded the hilar lesion as originating from past infection. On August 12, 2022, the Ottawa Valley MRI was officially reported as normal; quantitative paramagnetic phase analysis identifies seven unreported findings. On August 24, 2022, an urgent neurology referral requested a neurosurgical shunt consultation twelve days after that report.

More than five and a half years have elapsed since the December 4, 2020 malignancy impression. The reviewed record does not document completed OGD, definitive tissue diagnosis, oncological referral, HIV or syphilis testing, or antiretroviral therapy at any point. The formal pathology report from the September 28, 2020 Provis Rudd colonoscopy has not been provided to the patient; the record access history is detailed in Section 14.5. The anorectal lesion documented in patient-held photographs and confirmed present at both colonoscopy encounters has not been biopsied at any documented clinical contact. Lynch syndrome screening has not been confirmed as initiated or offered.

The standard-of-care questions arising from this record — radiological reporting, EBUS-TBNA immunophenotyping, HIV and syphilis management, OGD indications, lower GI documentation, and the causal relationship between the documented delays and disease trajectory — are framed in Section 14. This analysis presents documented observations and identified inferences, distinguished throughout. Causal and legal determinations require independent expert clinical opinion with primary access to all source documents and DICOM data. The management of advanced HIV/AIDS-associated malignancy in this context requires palliative and curative care integration as a clinical and ethical obligation [1,2].

19. References

Vancouver format. Numbered in order of first appearance.

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APPENDIX A — Source Inventory and Exhibit Catalogue

This appendix contains the full document-by-document inventory of records reviewed, DICOM metadata, and exhibit catalogue. All 64 items are catalogued below. Items in the main text are referenced to this appendix.

A.1 Clinical Chart Records

Ottawa Hospital MyChart Summary 1	Jul 29, 2021 272 pp Encounter log Nov 2020–Aug 2021; full OLIS labs; Beauchesne Jul 15 cardiology note; cardiac MRI Jul 26; Heart Function Clinic Aug 10; full medication list
Ottawa Hospital MyChart Summary 2	Jul 5, 2021 231 pp Physician progress notes: Beauchesne Nov 13, 2020; Rajchgot Dec 14, 2020; Amjadi Feb 22, Apr 19, May 20, Jul 5, 2021
Ottawa Hospital MyChart Summary 3	Jul 5, 2021 231 pp Patient Health Summary; Dr. Amjadi Jul 5 CAC telehealth note; plan including ID appointment Oct 25, 2021
CHI Chart Export — October 2020	Oct 2020 ~240 pp NP Batsch SOAP notes Oct 7 and 20; PHQ-9 21; GAD-7 16; Bigelow referral; CMHA referral; FASD referral; medication lists
CHI Chart Export — December 2020	Dec 2020 115 pp CT angiogram verbatim; EBUS procedure note and BAL; Persantine Myoview verbatim; Dec 10 OLIS panel; NIHB referral; Dec 8 SOAP; Dec 9 Rizkalla referral
CHI Chart Export — Jan–Nov 2021	2021 ~69 pp Amjadi AVS Jan 11; Fitzpatrick e-consult Jan 8; NP Batsch Jan 5 (colonoscopy confirmation); Feb 19 referral to Dr. Mattas; Feb 21 Seely email; CT reports

A.2 DICOM Imaging Studies — Directly Possessed and Reviewed

MRI Head w/+w/o Contrast	Dec 17, 2020 738 MB CCH, GE Optima MR450w 1.5T MR-20-0003946 Pixel analysis: S3, S4, S5, S6, S7, S8, S9, S10, S300, S500/S501, S700
CT Chest with Contrast	Feb 6, 2021 425 MB Dr. Alnemer (CPSO #122496, INACTIVE)
CT Chest without Contrast	May 10, 2021 562 MB Dr. Gerson (PGY-2, CPSO #118618)
RAD Chest plain film	Aug 11, 2021 35.02 MB Likely Montfort Hospital encounter
Chest PA & LAT (X091)	Nov 15, 2021 28.29 MB
Chest PA & LAT (X091)	Jul 2, 2022 27.47 MB
Ottawa Valley MRI Brain	Aug 12, 2022 Study ID 150086 Dr. Simantirakis FRCPC SWI series t2_swi_wave4_2mm_SWI (80 frames, 2 mm) directly reviewed

A.3 Radiology Reports — Not in Possessed DICOM Series

CT Angiogram Thoracic Aorta	Dec 4, 2020 Dr. Beauchesne (ordered) Verbatim impression: 'Findings are concerning for malignancy...'
ECHO TTE	Nov 3, 2020 Report only EF 54.5%; aortic root 4.4 cm
Cardiac MRI with gadolinium	Jul 26, 2021 Dr. Alnemer (report only) Focal LGE mid-lateral wall

PET Scan (staging)	Dec 31, 2020 Report only T1N0M0 under NSCLC; GEJ not primary investigative focus
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A.4 Procedural and Pathology Documents

EBUS-TBNA Procedure Note	Dec 16, 2020 Dr. Kayvan Amjadi R.O.S.E. positive station 11R; emergent CAC referral
EORLA Cytology CY-20-12991	Dec 17, 2020 Dr. Anna Adamiak FRCPC Station 11R: atypical cells; cell block inadequate; no IHC
Central Intake MRI Requisition IMG012001	Dec 10, 2020 Dr. Ramanadhan Indication: 'Advanced lung cancer. Staging'

A.5 Clinical Correspondence and Referral Letters

NP Batsch NIHB Referral Letter	Dec 15, 2020 CNO #11460983 'Urgently referred...possible metastatic lung cancer'; 'Aortic dilatation — severe'
Dr. Rizkalla letter to NP Batsch	Dec 29, 2020 Cumberland Clinic 'He was recently diagnosed with lung cancer. This doesn't change anything...' Notation: 'Dictated but not read'
Dr. Amjadi AVS	Jan 11, 2021 MRN 36358695 Clindamycin; CT chest ordered; GEN CANCER ASSESSMENT appointment requested
NP Batsch referral to Dr. Mattas	Feb 19, 2021 CNO #11460983 'I am unsure when or if this happened or what the results are' re colonoscopy; antisocial personality characterisation; NON-URGENT
Dr. Seely email to patient	Feb 21, 2021 CONO #1169 'When it turned out this diagnosis was in fact an error...'
NP Batsch email to patient	Oct 21, 2020 Re colonoscopy: 'Your memory really is incredible and in this case very helpful'
Urgent Neurology Referral	Aug 24, 2022 Dr. Caroline Filipowska to Dr. Mark Aaron Bernstein, Toronto Western 'has had great difficulty getting support'

A.6 Laboratory Reports

PHO LIMS #42656731 (HIV/Syphilis/HSV)	Oct 4, 2021 Dr. Mohan Pandit, Teletest.ca HIV Non-Reactive; Syphilis Non-Reactive; HSV-1 IgG Reactive
EORLA panel	Feb 24, 2021 IgE 754 IU/mL (H 3.14× ULN); CRP 7.8 mg/L (H); IgG4 1.62 g/L (normal); ANA/ANCA negative
LifeLabs 2021-X42011533	Jul 20, 2021 Dr. Livingstone ESR 49 mm/hr (H, peak); CRP 7.1 mg/L (H); testosterone 4.1 nmol/L (L, confirmed on repeat)
Dynacare YN19974372	Jun 9, 2021 Dr. Mattas WBC 12.4 ×10 ³ /μL (H); platelets 467 ×10 ³ /μL (H); free testosterone 570 pmol/L (H)
LifeLabs JZ0340694	Feb 3, 2021 NP Batsch CRP 5.8 mg/L (H); ferritin 23 μg/L (L); ESR 20 mm/hr
Montfort Troponin T	Aug 11, 2021 10 ng/L (normal <15); drawn 7:52 PM — previously undocumented hospital encounter
Dynacare YN21252819	Aug 25, 2021 Dr. Lalonde-Kontio, UnionMD-Gatineau Ordered at Aug 24, 2021 encounter to rule out infectious aetiology for myocarditis, H. pylori

PHO LIMS #42225226 (Toxoplasmosis)	persistence, and onychomycosis Candida IgE 0.05 kU/L (normal — excludes Candida as driver of IgE 754). Cross-reference: UnionMD Clinical Note 2021-08-24; PHO LIMS #42225226 (TOXO panel ordered same encounter).
	Aug 25–26, 2021 IgG Non-Reactive; IgM not performed

A.7 Psychiatric and Legal Records

Dr. Jack Klein — Confirmation letter	May 18, 2018 FRCP(C) Diagnoses ASD + PTSD confirmed; under care since 2016
Dr. Jack Klein — Progress Notes	Nov 10, 2016 – May 30, 2018 14 sessions; CICB proceedings; Abilify-induced Parkinsonism Oct 2017
Dr. Klein — CPP Disability Medical Report	Jan 20, 2017 Asperger's disorder (main disabling condition); prognosis 'Poor — any improvement is unlikely'
Dr. Klein — CICB Therapy Report	Oct 16, 2017 File 1307-92976 Childhood sexual abuse; CICB hearing Feb 9, 2018 — successful
Dr. Krishnaprasad records (Appletree)	May 2013–Feb 2015 7 encounters; all 'Dictated But Not Read'; Axis I PTSD + Bipolar II; medication escalation
Dr. Wassef consultation letter	Jan 15, 2015 Cornwall Axis I: chronic anxiety + PTSD; BDI 44 (severe); Nozinan added
CMHA Ottawa Eligibility Referral	Nov 3, 2020 NP Batsch ASD + PTSD documented; Dr. Klein listed; exceptional memory acknowledged
Ontario Probation Reports — Janice Bertrand	Sep 25, 1970 District of Nipissing Public Health Nurse Blais: 'several of the children are abnormal, both physically and mentally'
Ontario Probation Reports — Jean Bertrand	Oct 6, 1971 District of Nipissing File 6633

A.8 Naturopathic Visit Notes

Dr. Dugald Seely ND — Nov 12, 2020	CONO #1169 Pre-EBUS peripheral neuropathy: 'lack of sensation in hands and issues in feet'
Dr. Dugald Seely ND — Dec 17, 2020	Same-day MRI; NSCLC framing; repeat-MRI notation; melanic stool documented
Dr. Dugald Seely ND — Oct 29, 2021	Problem list: 'Right hilar lesion w/bronchial wall thickening from 'past infection''

A.9 Dental Records

Hog's Back Dental — Chart Notes	Printed Nov 1, 2021 Dr. Brian Yip DDS Sep 15 (SIP/SAP tooth 36, PARL); Sep 24 (extraction 36); Sep 28 (NPE — generalised moderate-severe chronic periodontitis); Oct 14 (restorations)
Hog's Back Dental — Periodontal Chart	Sep 28, 2021 Stage III generalised periodontitis (2017 AAP/EFP); probing 3–6 mm; bleeding on probing; sites 5–6 mm teeth 15–16, 24–27

A.10 Patient Photographic Documentation

Lower GI Haemorrhage Series	2024–2026 Serial haematochezia; Image 16: pencil-calibre ribbon stool (U-shape); Image 18: elongated tissue fragments with mucoid cap
Perianal/Rectal Photographs (Image 20)	Three-panel composite Large exophytic rectal lesion at anal verge with surface ulceration and circumferential indurated perianal tissue
DICOM Viewer Screenshots — CT Feb 6, 2021	MPR triplanar and axial screenshots; crosshairs on GEJ abnormality across all planes; annotation circles on soft tissue mass
Right Foot Dermatological Series — Pre-Dr. Lalonde-Kontio Encounter (Images 1000045598–1000045601)	Four-image series, patient-confirmed taken immediately prior to encounter with Dr. Lalonde-Kontio, Gatineau (Dynacare YN21252819, Aug 25, 2021). Image 1000045600: dorsal view, right foot — severe diffuse xerosis across full dorsum; pronounced scaling at all toe bases and periungual regions; onychomycotic nail plate involvement across all visible toes (thickening, discolouration, crumbling); generalised skin texture abnormality. Image 1000045598: close-up dorsal view, toes — severe onychomycotic destruction of great toe nail plate with overlying hyperkeratotic debris; deep interdigital fissuring and lichenification; terminal phalangeal morphology partially obscured by onychomycotic process, precluding reliable Lovibond angle assessment. Image 1000045599: lateral heel view — confluent severe hyperkeratosis of posterior heel and calcaneal pad; deep fissuring with cracking through to apparent dermal layer; scale build-up consistent with ichthyosis-pattern change rather than environmental dryness alone; severity consistent with reduced protective sensation in context of documented peripheral neuropathy NYD. Image 1000045601: plantar view, full sole — hyperkeratotic change extending from posterior heel through mid-arch to metatarsal heads; area of violaceous discolouration in mid-plantar region distinct from surrounding hyperkeratosis (differential: subkeratotic haemorrhage, early tissue breakdown, vascular change); heel fissuring confirmed at posterior margin. Forensic relevance: (1) severity and distribution of onychomycosis and hyperkeratosis consistent with significant immune compromise in context of inferred advanced HIV — not typical presentation of isolated tinea unguium in immunocompetent patient; (2) plantar and heel changes consistent with neuropathic foot in context of documented peripheral neuropathy NYD and reported painful feet and difficulty walking; (3) skin texture and fissuring pattern relevant to EDS hypermobility spectrum differential (impaired wound healing, skin fragility); (4) periungual and dorsal scaling relevant to Leser-Trélat and broader cutaneous paraneoplastic assessment. Cross-reference: Appendix B — Toenail Photographs assessment entry; Section 15 (Leser-Trélat); Section 10.1 (peripheral neuropathy NYD).

A.11 Correspondence and Third-Party Primary Sources

Email — Bertrand to Dr. Francis E. Nano PhD	Jun 28, 2021 University of Victoria Confirms prior lab visit and toxoplasmosis outbreak severity
Times Colonist — 'Parents critical of baby's delivery'	Feb 13, 1993 Denise Helm Jamieson Bertrand complications; archived at newspapers.com images 508330203, 508329811
Multi-Institutional PHIPA Access Email	Feb 6, 2023, 4:27 PM From: rizzler52@outlook.com 14 recipients across five institutions: Ottawa Hospital (Board, Patient Relations, Dr.

— Bertrand to 14 Recipients	Amjadi); CHI / Wabano (NP Batsch, general inboxes); Ottawa Heart Institute (quality); Provis Endoscopy; PES Rudd Clinic Ottawa; CHEO; Yang Medicine Full recipient list in Appendix B (Patient's Written Records Requests entry) Attachment: Lynch syndrome / HNPCC clinical literature PDF Subject: record access request re Provis Rudd pathology report No reply from any recipient documented in reviewed record. Cross-reference: Appendix B — Provis Rudd Pathology and PHIPA Access entries; Section 14.5.
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A.12 Cornwall Health Care Centre Records

CHCC Chart Record	Nov 17, 2014 – Jun 21, 2016 Dr. Heeley-Ray et al. Key: Mar 31/2015 WBC 13.5 (H), ECG sinus tachycardia; Apr 6/2015 'was seeing Dr. Scharf re: polyps' — earliest GI polyposis reference; Mar and Jun 2016 ECGs QRS 114 and 112 ms. Cross-reference: Hôpital Montfort ECGs Apr 2, Apr 23, Oct 11, 2009 (Appendix A.14) establish IVCD QRS 112 ms seven years prior to these Cornwall ECGs.
Dr. Wassef consultation from CHCC	Jan 15, 2015 See A.7 above

A.13 UnionMD-Gatineau Clinical Records — Dr. Ginette Anne Lalonde-Kontio

UnionMD-Gatineau Clinical Note — Aug 24, 2021	Aug 24, 2021, 11:24 86 Prom Du Portage, Gatineau QC J8X2K1 Tel: (514) 400-3291 Signed: Dr. Ginette Anne Lalonde-Kontio, 2021-08-24 Reason for visit: physical examination Vitals: BP 118/84, HR 78 bpm, RR 18/min, pain 1/10 DERM: +++ dry scaling keratotic skin at heels and plantar aspect of feet; +++ ungal [sic] thickening and discolouration of nails (right foot more than left); no erythema, normal skin temperature CVS: S1/S2, no murmur, normal peripheral pulses bilaterally RESP: AE=AE clear, no accessory muscle use ABDO: soft, no guarding, no rebound, no mass, no visceromegaly MSK/NEURO: normal muscle bulk/tone, normal gait, power 5/5, DTR+2 biceps/patella, normal sensory screening, normal Rhomberg HPI documents: infectious aetiology discussion (toxoplasmosis, HSV); severe onychomycosis on Lamisil with modest improvement; labile hypertension on prior Amlodipine/Coversyl HD; patient-initiated switch to Bisoprolol with BP normalisation Plan: ELISA and TOXO gondii requisition; Urea 10% ointment; Bisoprolol continued; patient to forward full medical dossier to UnionMD Page 1 of 2.
UnionMD-Gatineau Follow-up Note — Sep 7, 2021	Sep 7, 2021, 12:09 UnionMD-Gatineau Signed: Dr. Ginette Anne Lalonde-Kontio, 2021-09-07 Reason: laboratory follow-up and Bisoprolol Bisoprolol well tolerated; home BP 102–122/52–62 mmHg Patient reports stabbing intense pain at right upper hilar region Lamisil well tolerated; notable improvement in heel skin quality CXR Aug 12, 2021 reviewed: lungs normal, no pleural effusions, heart normal limits, mild unfolding of thoracic aorta, no interstitial pulmonary oedema Assessment: B351 Tinea unguium (Chronic Active); I100 HTA bénigne (Controlled) Plan notes (verbatim): "Consultation in infectious disease is pending"; "Consultation for colonoscopy due to FHx of colorectal disease. The patient has a documented history of rectal polyps and rectal bleeding."; repeat hepatic profile; repeat male hormone profile; cardiologist follow-up with ECG Holter Forensic significance: independent third-party colonoscopy referral corroborating Section 14.4 standard-of-care analysis; right upper hilar pain

	persisting post-retribution; third modality aortic abnormality documentation.
UnionMD-Centre Ville Refund Receipt — Invoice 283641	Sep 20, 2021 Invoice 283641 Visit date 2021-09-20 Provider: Dr. Lalonde-Kontio, Ginette Anne UnionMD-Centre Ville, 1191 Av. Union, Montréal QC H3B3C3 Remboursement (refund): -\$275.00 CAD Payment method: Mastercard ending 2675 Batch 423, trace 22, approved 15:07:56 Signed: Mme Vacchiero, Anne, 2021/09/20 15:08:32 Primary source financial documentation of patient's engagement with UnionMD clinical pathway; corroborates contemporaneous clinical encounter series.

A.14 ECG Series and Patient-Held BP Documentation

Hôpital Montfort ECG Series — Apr 2, Apr 23, Oct 11, 2009	Three ECGs, Hôpital Montfort — Main Campus, Dept: Service d'Urgence / Urgence. Patient: Bertrand, Ricki Darren Jos, DOB 27-Feb-1966. MRN M0549714. (1) Apr 2, 2009, 11:24:34 Order 20090402-0040 HR 93, PR 136, QRSD 112, QT 356, QTc 443 Axis: P 73, QRS -30, T 31 Interpretation: Sinus Rhythm; Nonspecific Intraventricular Conduction Delay, QRSD >110mS, not LBBB/RBBB ABNORMAL ECG Signed: Chamoun Chamoun M.D. FRCP(C) Reason: douleur thoracique. (2) Apr 23, 2009, ~11:24 Order 20090423-0009, Enc UI002347/09 HR 94, PR 144, QRSD 112, QT 352, QTc 441 Axis: P 41, QRS 37, T 24 Interpretation: Sinus Rhythm; Nonspecific Intraventricular Conduction Delay, QRSD >110mS, not LBBB/RBBB ABNORMAL ECG Previous ECG: 02-Apr-2009 — Abnormal Confirmed Signed: Binny Kuriakose M.D. FRCP(C) Reason: Douleur thoracique; Requested by: Carpentier, Marie. (3) Oct 11, 2009, 22:58:24 Order 20091011-0044, Enc UI021989/09 HR 70, PR 148, QRSD 112, QT 400, QTc 432 Axis: P 47, QRS 66, T 32 Interpretation: Sinus Rhythm; Nonspecific Intraventricular Conduction Delay, QRSD >110mS, not LBBB/RBBB Previous ECG: 23-Apr-2009 — Abnormal Confirmed Signed: David Schneiderman M.D. FRCP(C) OE Comm: Pressure, SOB; Requested by: Owen, Diana C. Forensic significance: establishes IVCD QRSD 112 ms with FRCP(C)-confirmed Abnormal ECG designation at Hôpital Montfort since at least April 2, 2009 — twelve years before Dr. Beauchesne characterised it as a new finding in July 2021. Serial cross-referencing between strips confirms Montfort system tracked this as a persistent confirmed cardiac abnormality across multiple emergency presentations in 2009. Extends the IVCD timeline seven years prior to the earliest Cornwall ECG documentation (March 2016).
Cornwall ECG Series — Mar 31, 2015; Mar 17 and Jun 21, 2016	Three ECGs via LifeLabs Medical Laboratory Service, McConnell Med. Ctre, Cornwall ON K6H 4M4. Patient: Bertrand, Ricki Darren Jos, PHN 1916837402. Confirmed interpretation by Dr. P. DeYoung for all three. (1) Mar 31, 2015 Accession W50900720 To: Dr. L. Scharf (1490801) HR 102, PR(ms) 126, QRS(ms) 102, QTc 423 QRS Axis -43 Interpretation: Sinus Tachycardia; Left Axis Deviation QRS 102 ms (borderline; below 110 ms IVCD threshold). (2) Mar 17, 2016 Accession W56770428 To: Dr. Dylewski HR 70, PR(ms) 138, QRS(ms) 114, QTc 403 QRS Axis -29 Interpretation: Sinus Rhythm; Leftward axis deviation. (3) Jun 21, 2016 Accession W57731134 To: Dr. A. Rosenbloom HR 58, PR(ms) 142, QRS(ms) 112, QTc 396 QRS Axis -14 Interpretation: Sinus Rhythm, Normal ECG (QRS 112 ms at borderline of IVCD threshold; same confirming physician Dr. P. DeYoung). Cross-reference: Hôpital Montfort ECG series (above) establishes QRSD 112 ms with formal IVCD designation seven years prior.

Patient-Held Home BP Log — Jun–Jul 2021 (PhysioLogic EssentiA+)	Five patient-held photographic BP readings, PhysioLogic EssentiA+ device, confirmed 2021. Period of active TRT and multi-agent antihypertensive therapy preceding Dr. Amjadi CAC telehealth Jul 5, 2021 and UnionMD-Gatineau encounter Aug 24, 2021. Readings: Jun 13, 9:40 AM — 166/103 mmHg, HR 75 (Stage 2 HTN, highest systolic in series); Jun 16, 6:19 PM — 157/88 mmHg, HR 75; Jun 30, 10:58 AM — 154/101 mmHg, HR 103 (tachycardia); Jul 4, 10:34 AM — 146/106 mmHg, HR 110 (tachycardia, highest diastolic); Jul 4, 8:37 PM — 158/103 mmHg, HR 70 (reverse diurnal: evening higher than AM). All five readings confirm Stage 2 hypertension (systolic ≥ 140 and/or diastolic ≥ 90). Sustained diastolic 101–106 mmHg documented in context of aortic root 44.0–46.2 mm and inferred cardiovascular syphilis. Jul 4 readings (one day pre-Amjadi CAC encounter) place patient in hypertensive urgency range; no BP assessment documented at Jul 5 CAC telehealth. No institutional encounter documented this hypertensive state during Jun–Jul 2021. Cross-reference: UnionMD Aug 24, 2021 BP 118/84 on Bisoprolol — documents haemodynamic improvement following medication change.
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A.15 Testosterone Enanthate Prescription Label Series

Patient-held physical prescription labels from retained Delatestryl (testosterone enanthate) vial packaging. Eleven photographs across two imaging dates (20240415 and IMG_20250812 series) document ten distinct dispensing events. The active TRT period is bracketed by the laboratory record: pre-treatment baseline testosterone 5.7 nmol/L (July 2019, Appendix C); supratherapeutic 33.3 nmol/L confirmed December 2019 corresponding to Rx 9783324 (Dr. Prupas, 200 mg/week initiation); peak supratherapeutic 36.6 nmol/L August 2020 (Appendix C); declining to 25.7 nmol/L June 2021 and near-castrate 4.1 nmol/L July 2021 (confirmed on repeat, 84% fall over 41 days), consistent with effective cessation or near-cessation. Active supratherapeutic TRT exposure window: approximately December 2019 through mid-2021 — a period spanning the carcinogenic progression window and the clinical encounter series documented in this analysis. Five prescribers and three Cornwall-area pharmacies are documented. No inter-prescriber coordination documentation and no testosterone monitoring documentation appear in any reviewed clinical record across this period. All labels confirm patient identity as Bertrand, Ricki Darren (variants: “Ricki Bertrand,” “Bertrand, Ricky”) and drug as Delatestryl (testosterone enanthate), DIN 00029246, Valeant Canada, Laval QC H7L 4A8.

Rx / Transaction #	Prescriber Pharmacy Dose Instruction Lab Correlation
Rx 9783324 Fill: Dec 02, 2019	Dr. D. Prupas Shoppers Drug Mart / E. Hamed Drug Store Inc., 1236 Brookdale Ave, Cornwall — Store #0606 — Tel: 613-938-3010 Refills: 0 Delatestryl 200 mg/mL INJ 5 mL INJECT 1 MILLILITRE(S) INTRAMUSCULARLY EVERY WEEK FOR 10 WEEKS 200 mg/week. Lab correlation: testosterone total 33.3 nmol/L, free testosterone 738 pmol/L (1.55 $\times$ ULN) confirmed December 2019 — supratherapeutic, temporally consistent with this 200 mg/week initiation (Appendix C).
Tx #70761599 Fill: Jan 26, 2020	Prescriber: Prupas / Dylewski (prescriber face partially obscured) Shoppers Drug Mart / E. Hamed Drug Store Inc., Cornwall — Store #0606 Refills: 2 Delatestryl 200 mg/mL ENAN INJ 5 mL — DIN 00029246 Inject 1 mL intramuscularly every week 200 mg/week.
Tx #70762567 Fill: Mar 29, 2020	Prescriber: Prupas / Dylewski (prescriber face partially obscured) Shoppers Drug Mart / E. Hamed Drug Store Inc., Cornwall — Store #0606

Rx / Transaction #	Prescriber Pharmacy Dose Instruction Lab Correlation
	Delatestryl 200 mg/mL ENAN INJ 5 mL — DIN 00029246 Inject 1 mL intramuscularly every week 200 mg/week.
Tx #70763548 Fill: Jun 08, 2020	Prescriber: Prupas / Dylewski (prescriber face partially obscured by overwrap) Shoppers Drug Mart / E. Hamed Drug Store Inc., Cornwall — Store #0606 Delatestryl 200 mg/mL ENAN INJ 5 mL — DIN 00029246 Dose instruction face partially obscured; 200 mg/week inferred from series continuity.
Rx 9777680 Fill date not legible	Dr. I. Dylewski Shoppers Drug Mart / E. Hamed Drug Store Inc., Cornwall — Store #0606 Delatestryl 200 mg/mL INJ 5 mL INJECT 1 MILLILITRE(S) INTRAMUSCULARLY EVERY WEEK (LU 397) 200 mg/week. LU 397 notation: Ontario Drug Benefit Limited Use code for testosterone enanthate, requiring physician attestation of hypogonadism criteria at time of prescribing. The ODB attestation document filed at this prescribing event is a potentially discoverable primary source record confirming the formal clinical justification for TRT as documented by Dr. Dylewski; this document is not in the currently reviewed record.
Rx 9498944-0064 Fill: Aug 2020 (confirmed by label)	Dr. T. Tyson PLT INC. (Paul Trottier), 5, 9 lème Rue Est, Cornwall ON — Tel: 613-938-7339 Delatestryl 5 mL / Testosterone Enanthate 0.5 mL once a week; 5 mL vial Q60 days (last 70 days); dispensing date 10-Aug-2020 confirmed on label 100 mg/week. Lab correlation: testosterone total 36.6 nmol/L August 2020 — most suprathreshold value in the record — temporally consistent with this prescribing period despite lower nominal dose, possibly reflecting altered androgen clearance in context of concurrent disease burden (Appendix C).
Rx 9502937-0064 Fill: Dec [year partially obscured]	Dr. T. Tyson PLT INC. (Paul Trottier), Cornwall — Tel: 613-938-7339 Delatestryl 5 mL / Testosterone Enanthate 0.5 mL once every [cycle]; 5 mL Q60 days (last 70 days); LU 397 ~100 mg/week. Year of fill not confirmed from label; date range bounded by laboratory record (Appendix C).
Rx 9783976 Fill date not legible	Dr. P. Hierlihy Shoppers Drug Mart / E. Hamed Drug Store Inc., Cornwall — Store #0606 Delatestryl 200 mg/mL INJ 5 mL — DIN 00029246 INJECT 0.5 MILLILITRE(S) EVERY WEEK 100 mg/week. Dose reduction from 200 mg/week (Prupas/Dylewski series) to 100 mg/week documented at this prescribing event.
Rx 9420873[x] Fill date not legible	Dr. Shawn Mattas Pharmasave 5 mL Delatestryl / Testosterone Enanthate — DIN 00029246 50 MG ONCE [EVERY x] WEEKS ~50 mg/week (0.25 mL of 200 mg/mL formulation) — lowest prescribed dose in the series. Prescribing context: Dr. Mattas documented as patient's Wabano-affiliated physician in CHI and Wabano records; Pharmasave prescription represents a prescribing event outside the Cornwall Shoppers/PLT INC. pharmacy chain.
Rx [partially legible] Fill: 25-Feb-202[0 or 1]	Prescriber not legible Respect Rx (2406030 Ontario Inc.), 3-805 Sydney St., Cornwall ON K6H 3[...] — Tel: 613-209-7778 Testosterone Enanthate 1000 mg/5 mL (200 mg/mL); Mfr: VCN; Refills: 0 WEEKLY FOR 20 [weeks] Patient identified as "Bertrand, Ricky" — spelling variant, confirmed same patient. Per-injection volume not fully legible; if 1 mL/week from 200 mg/mL vial, dose = 200 mg/week over a 20-week course. Year of fill not confirmed; bounded by laboratory record (Appendix C).

Prescriber summary: Five independent prescribers documented: Dr. D. Prupas (TRT initiation, Dec 2019, 200 mg/week); Dr. I. Dylewski (200 mg/week, LU 397 attestation); Dr. T. Tyson (100 mg/week, PLT INC., Aug 2020 confirmed); Dr. P. Hierlihy (100 mg/week, dose reduction event); Dr. Shawn Mattas (50 mg/week, lowest dose, Pharmasave). Three pharmacies: Shoppers Drug Mart / E. Hamed Drug Store Inc., Cornwall (Store #0606); PLT INC. (Paul Trottier), Cornwall; Respect Rx, Sydney St., Cornwall. No clinical handoff documentation between prescribers and no testosterone monitoring documentation by any prescriber appear in any record in the reviewed series across the full TRT period.

Forensic significance: The label series establishes that suprathreshold androgen exposure during the carcinogenic progression window (December 2019 through mid-2021) was the result of active multi-prescriber prescribing without documented inter-prescriber coordination or serum testosterone monitoring. The standard physiological replacement range for testosterone enanthate is 50–100 mg/week; 200 mg/week (the initiating and predominant dose in this series) is at or above the upper boundary of replacement dosing. The NK cytotoxicity suppression mechanism cited in Section 15 — by which suprathreshold androgens reduce natural killer cell activity during the period of GEJ carcinogenesis — is directly anchored to this primary source prescribing record. The five-prescriber, three-pharmacy configuration without documented coordination raises a parallel standard-of-care question regarding androgen monitoring obligations, independent of the oncological and infectious disease questions addressed in Sections 14.1–14.5. The LU 397 ODB attestation document filed by Dr. Dylewski at the time of his prescribing event is a potentially discoverable primary source record not yet in the reviewed series. Cross-reference: Appendix C (testosterone serial values Jul 2019, Dec 2019, Aug 2020, Jun–Jul 2021); Section 3 chronology (Jul–Dec 2019 and Aug 2020 entries); Section 15 (TRT and NK suppression).

APPENDIX B — Outstanding Evidentiary Items

The following items remain unresolved in the reviewed record and require formal retrieval or independent assessment before the evidentiary record can be considered complete for medico-legal purposes.

PRIORITY — January 14, 2021 Colonoscopy Outcome [RECORD PENDING — RETRIEVAL REQUESTED]	STATUS: Record not yet received. Retrieval from Cumberland Clinic / Dr. Rizkalla required. Confirmed by three independent contemporaneous sources: Rizkalla letter (Dec 29, 2020), NP Batsch Jan 5, 2021 note, and NP Batsch Feb 19, 2021 referral (“I am unsure when or if this happened or what the results are”). No colonoscopy report or result is documented in the reviewed record. The anorectal lesion documented in patient-held photographs (Image 20) was present at this encounter and would have been encountered at pre-procedure external inspection; whether it was documented or biopsied cannot be determined without the procedural report. This is a primary evidentiary gap (see Section 12.3, Appendix B — Provis Rudd Formal Pathology Report).
PRIORITY — Provis Rudd Formal Pathology Report, Sep 28, 2020 [RECORD PENDING — RETRIEVAL REQUESTED]	The formal laboratory pathology report from the September 28, 2020 Provis Rudd colonoscopy — with accession number, specimen inventory by anatomical site, microscopic findings, and sign-out pathologist — has not been provided to the patient despite repeated written requests. The Bigelow letter of October 29, 2020 (“Dictated But Not Read”) provides a summary characterisation only. The primary report is required to verify: (1) which anatomical specimens were submitted; (2) whether any tissue from the anorectal region was sampled; (3) the full microscopic findings for each specimen; and (4) whether MMR immunohistochemistry or MSI testing was performed, which is required to evaluate Lynch syndrome given the patient’s documented family history (father: colon cancer at age 60; multiple colorectal polyps including tubular adenoma at age 54) consistent with revised Bethesda guideline screening criteria. Record access history is documented in Appendix A.11 (Multi-Institutional PHIPA Access Email). Retrieval may require formal legal discovery or an IPC complaint under PHIPA s. 56.
Patient’s Written Records Requests to Provis Rudd Endoscopy — Documentation	The patient’s written requests to Provis Rudd Endoscopy for the formal pathology report are documented primary source exhibits. The February 6, 2023 written communication (sent 4:27 PM, rizzler52@outlook.com) was addressed to fourteen institutional recipients across five institutions: Ottawa Hospital (Board of Directors, Department of Patient Relations, Dr. Amjadi); CHI / Wabano (NP Batsch, general inboxes, J. Soucie); Ottawa Heart Institute (quality); Provis Endoscopy; PES Rudd Clinic Ottawa; CHEO; Yang Medicine; and G. Cote (Ottawa Hospital). The communication attached Lynch syndrome / HNPCC clinical literature and referenced the outstanding pathology report. No reply from any recipient is documented in the reviewed record. Cross-reference: Bigelow letter Oct 29, 2020 (“Dictated But Not Read”); Rizkalla letter Dec 29, 2020 (“Dictated but not read”) — notation pattern across two independent GI clinicians within a four-month period. Record access remedies (PHIPA complaint, IPC, legal discovery) remain available; see Section 14.5.
Higouménakis Sign — MSK Radiology Assessment	Right medial clavicular cortical irregularity and asymmetry documented on CT (Series 601 frames 65–68; Series 602 frames 13–18). Consistent with but NOT confirmed as Higouménakis sign. Independent expert musculoskeletal radiological assessment required before characterised as confirmed.

Prior Brain MRI (Pre-Dec 17, 2020)	Referenced in Dr. Seely's Dec 17, 2020 note as repeated 'based on error done in first case.' Not in possessed DICOM series. If formally reported, may constitute an additional MRI reporting failure. Retrieval from Ottawa Hospital radiology required.
EBUS Cytology Stations 4R and 7 [RECORD PENDING — MYCHART ATTACHMENTS UNAVAILABLE]	Accession numbers CY-20-12992 (station 4R) and CY-20-12993 (station 7) listed in Ottawa Hospital MyChart as attachments not available. Full cytological characterisation of all three stations requires primary pathology slide/block access.
Plain Film Series — Formal Radiological Review	Three plain films in possessed DICOM series (Aug 11, Nov 15, 2021; Jul 2, 2022) have not undergone formal per-film forensic radiological analysis. Review for right hilar prominence, mediastinal widening, and pleural effusion at each time point required.
S300 Axial Reformat — Posterior Fossa/Brainstem (Inst001–048)	CCH MRI December 2020. Sections Inst001–048 of S300 posterior fossa/brainstem remain outstanding from the DICOM pixel analysis. These are the priority gap for the brainstem and posterior fossa assessment.
S7 SWAN / S700 FILT_PHA — Inst033+ Gaps	CCH MRI December 2020. Series S7 and S700 analysis outstanding for Inst033 onwards. Critical for full brainstem susceptibility characterisation.
S500/S501 ADC/eADC — Inst005–014 Gap	CCH MRI December 2020. Series S500 (ADC) and S501 (eADC) diffusion-weighted imaging: Inst001–004 reviewed (R anterior perimedullary T2 shine-through confirmed; bilateral posterior perimedullary true restriction consistent with PICA/posterior-spinal ischaemia; R corona radiata 7 clusters confirmed true restriction). Inst005–014 outstanding — gap in full-volume diffusion characterisation of right corona radiata and perimedullary restriction pattern.
Prolactin — Jul 5, 2019 and Feb 18, 2021	Pending lab values relevant to infundibular gumma and pituitary axis assessment.
CD4+ Count and HIV Viral Load	Not documented at any point in the reviewed period. Essential for staging the HIV disease burden and interpreting all serological results. Formal testing through supervised clinical pathway required.
Independent Oncological Expert Opinion	Formal medico-legal expert opinion from a qualified clinical oncologist with primary access to all source documents and physical DICOM data is required for causal and legal determinations. This analysis is a preparatory framework.
Toenail and Foot Dermatological Photographs (Images 918, 920; 1000045598–1000045601) — Digital Clubbing and Cutaneous Assessment	Six images across two series. Images 918 and 920: indeterminate for digital clubbing — active onychomycosis prevents reliable Lovibond angle evaluation; nail plate deformity from fungal infection cannot be distinguished from convexity change characteristic of true clubbing. Images 1000045598–1000045601 (patient-confirmed pre-Dr. Lalonde-Kontio encounter, Aug 25, 2021): four-image right foot series documenting (a) severe diffuse dorsal xerosis with generalised onychomycotic involvement across all toes; (b) great toe nail plate destruction with hyperkeratotic debris and deep interdigital fissuring; (c) confluent posterior heel hyperkeratosis with deep dermal-level fissuring consistent with ichthyosis-pattern change and reduced protective sensation; (d) full plantar hyperkeratosis with violaceous mid-plantar discolouration (differential: subkeratotic haemorrhage, early tissue breakdown, vascular change). The severity and distribution of onychomycosis and hyperkeratosis across all six images is not consistent

	with isolated tinea unguium in an immunocompetent patient and warrants assessment in the context of inferred advanced HIV immunosuppression, documented peripheral neuropathy NYD, EDS hypermobility spectrum differential, and cutaneous paraneoplastic evaluation. Independent clinical assessment by a dermatologist with direct examination is required before digital clubbing can be characterised or excluded as a paraneoplastic finding. All six images retained as primary source documentation. Cross-reference: Appendix A.10; Section 15 (Leser-Trélat); Dynacare YN21252819 (Appendix A.6).
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APPENDIX C — Laboratory Values Reference Table

Serial values relevant to the forensic analysis, in chronological order. Reference ranges as per the laboratory source. Values flagged High (H) or Low (L) per the laboratory's reference at the relevant date.

Date	Analyte	Value	Flag	Forensic Relevance
Aug 12, 2020	CRP	8.1 mg/L	H	Highest pre-clinical CRP; active systemic inflammation predating first encounter
Aug 12, 2020	ESR	41 mm/hr	H	Elevated pre-clinical; ferritin 16 µg/L concurrent (below lower limit on TRT)
Aug 12, 2020	Testosterone total	36.6 nmol/L	H	1.27× ULN; most supratherapeutic value in record; carcinogenic window. Corresponds temporally to Dr. T. Tyson / PLT INC. prescribing period (Rx 9498944-0064, 100 mg/week, dispensing date 10-Aug-2020 confirmed on label). Cross-reference: Appendix A.15; Section 3 chronology (Aug 2020 entry).
Dec 10, 2020	ESR	35 mm/hr	H	Primary source confirmed (NP Batsch chart annotation Dec 22)
Dec 10, 2020	CRP	5.0 mg/L	H	Primary source confirmed
Dec 10, 2020	Ferritin	36 µg/L	low-normal	On active TRT — iron depletion pattern
Feb 3, 2021	CRP	5.8 mg/L	H	Three days before Feb 6 CT
Feb 3, 2021	Ferritin	23 µg/L	L	At absolute lower limit on TRT — supports chronic GI blood loss
Feb 3, 2021	ESR	20 mm/hr	N	Normal (within reference range, 0–20 mm/hr); contemporaneous with CRP 5.8 mg/L (H) and ferritin 23 µg/L (L) on same panel (LifeLabs JZ0340694)
Feb 24, 2021	IgE	754 IU/mL	H	3.14× ULN; Candida-specific IgE subsequently 0.05 kU/L (normal) — Candida excluded as driver
Feb 24, 2021	CRP	7.8 mg/L	H	EORLA reference ≤10.0 mg/L
Jun 9, 2021	WBC	12.4 ×10 ⁹ /L	H	With neutrophilia, lymphocytosis, monocytosis; platelets 467 (H) — reactive pattern
Jul 5, 2019	Testosterone total	5.7 nmol/L	L	Pre-TRT; LH 2.2 and FSH 2.6 paradoxically low-normal — infundibular lesion hypothesis. Pre-treatment baseline; TRT initiated Dec 2, 2019 (Rx 9783324, Dr. Prupas, 200

				mg/week). Cross-reference: Appendix A.15.
Dec 2019	Testosterone total	33.3 nmol/L	H	1.27× ULN; suprathreshold at TRT initiation. Corresponds to Rx 9783324, Dr. D. Prupas, 200 mg/week (Dec 2, 2019). Cross-reference: Appendix A.15; Section 3 chronology (Dec 2, 2019 entry).
Dec 2019	Free testosterone	738 pmol/L	H	1.55× ULN; confirms suprathreshold free androgen at TRT initiation. Corresponds to Rx 9783324, Dr. D. Prupas, 200 mg/week (Dec 2, 2019). Cross-reference: Appendix A.15; Section 3 chronology (Jul–Dec 2019 and Dec 2, 2019 entries).
Jul 20, 2021	ESR	49 mm/hr	H	Peak documented value in serial record
Jul 20, 2021	Testosterone total	4.1 nmol/L	L	~84% fall from 25.7 nmol/L (Jun 9) over 41 days; confirmed on repeat
Jul 20, 2021	Free testosterone	70 pmol/L	L	Reference 179–475 pmol/L
Aug 11, 2021	Troponin T	10 ng/L	N	Reference <15 ng/L; normal; drawn 7:52 PM at previously undocumented Montfort Hospital encounter (Appendix A.6). Excludes acute myocardial injury at this date; does not exclude subclinical chronic myocardial process (see cardiac MRI Jul 26, 2021: focal LGE mid-lateral wall).
Aug 16, 2021	Haemoglobin	135 g/L	low-normal	Lowest on record while on active TRT (was 156 g/L Jun 9); 21 g/L fall over 68 days
Aug 25, 2021	Candida IgE	0.05 kU/L	N	Normal (ref <0.35 kU/L); excludes Candida sensitisation as driver of IgE 754 IU/mL. Dynacare YN21252819; ordered at UnionMD encounter Aug 24, 2021 (Appendix A.6).
Aug 25–26, 2021	Toxoplasma gondii IgG	Non-Reactive	N	Non-Reactive IgG; IgM not performed — gap noted in the infectious aetiology workup. PHO LIMS #42225226; ordered at UnionMD encounter Aug 24, 2021 (Appendix A.6).
Sep 16, 2021	Triglycerides	3.00 mmol/L	H	TC/HDL 5.5; atherogenic lipid profile relevant to cardiovascular syphilis framework
Oct 4, 2021	HIV-1/2 Ag/Ab Combo; Syphilis Ab; HSV-1 IgG	NR / NR / Reactive	see note	PHO LIMS #42656731. Direct-to-consumer (Teletest.ca, Dr. Mohan Pandit). HIV-1/2 Ag/Ab Combo:

				Non-Reactive; Syphilis Ab: Non-Reactive; HSV-1 IgG: Reactive (past exposure). Limitations detailed in Section 10.2: 4th-generation combo without concurrent viral load and CD4+ does not exclude HIV at advanced AIDS-stage; seroreversion possible in late-stage syphilis. Result not documented as communicated to or actioned within Ottawa Hospital or CHI pathways (Appendix A.6).
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APPENDIX D — Reference Index: Diagnostic Claims to Primary Sources

This index maps each principal diagnostic claim or administrative finding in the analysis to its corresponding primary source record or appendix exhibit. Entries are grouped by domain. All source documents are catalogued in Appendix A; outstanding records are flagged in Appendix B.

Diagnostic Claim / Finding	Primary Source / Exhibit Reference
IMAGING — CT and PET	
CT angiogram, Dec 4, 2020: ‘concerning for malignancy’ impression	CHI Chart Export Dec 2020 (A.1); A.3 (report only)
CT chest with contrast, Feb 6, 2021: four unreported GEJ findings; aortic root 44.0–44.2 mm unreported	Directly possessed DICOM (A.2); CHI Chart Export Jan–Nov 2021 (A.1); Appendix C
CT chest without contrast, May 10, 2021: same four unreported GEJ findings; aortic root 45.5–46.2 mm unreported; no IV contrast acknowledged	Directly possessed DICOM (A.2); Ottawa Hospital MyChart Summary 2 (A.1)
IMAGING — MRI (CCH Dec 2020 and Ottawa Valley Aug 2022)	
CCH MRI Dec 17, 2020 (MR-20-0003946): 14 bilateral enhancing foci (S10); bilateral thalamic microhaemorrhages (S7/S700); R corona radiata restricted diffusion (S5); infundibular stalk asymmetry 2.9 mm (S9)	Directly possessed DICOM (A.2); Central Intake MRI Requisition IMG012001 (A.4)
Ottawa Valley MRI Aug 12, 2022: 7 unreported findings including infundibular gumma (tripplanar FLAIR), leukoencephalopathy, bilateral thalamic/basal ganglia SWI	Directly possessed DICOM (A.2); Urgent neurology referral Aug 24, 2022 (A.5)
PROCEDURAL — EBUS-TBNA and Cytology	
EBUS-TBNA Dec 16, 2020: R.O.S.E. station 11R ‘Positive for malignancy’ (verbatim); emergent CAC referral recommended	EBUS-TBNA Procedure Note Dec 16, 2020 (A.4); Ottawa Hospital MyChart Summary 2 (A.1)
EORLA cytology CY-20-12991: atypical cells; inadequate cell block; no IHC performed on station 11R material	EORLA Cytology CY-20-12991, Dec 17, 2020 (A.4)
LOWER GI — Colonoscopy and Pathology	
Anorectal lesion present at Sep 28, 2020 and Jan 14, 2021 colonoscopies; not referenced in either procedural record; no biopsy documented	Patient-held photographs Image 20 (A.10); Bigelow letter Oct 29, 2020 (A.5); Rizkalla letter Dec 29, 2020 (A.5)
Provis Rudd formal pathology report (Sep 28, 2020): not provided despite repeated written requests [RECORD PENDING]	Appendix B (PRIORITY — Provis Rudd); Appendix A.11; Section 14.5
Cumberland Clinic colonoscopy Jan 14, 2021 outcome: not confirmed in reviewed record [RECORD PENDING]	Appendix B (PRIORITY — Jan 14, 2021 Colonoscopy); Section 12.3
LABORATORY — Key Values	

Diagnostic Claim / Finding	Primary Source / Exhibit Reference
IgE 754 IU/mL (3.14× ULN, Feb 24, 2021)	EORLA panel Feb 24, 2021 (A.6); Appendix C
Testosterone total 33.3 nmol/L (Dec 2019, 1.27× ULN); free testosterone 738 pmol/L (1.55× ULN)	Appendix C; Appendix A.15 (Rx 9783324, Dr. Prupas); Section 3 chronology (Dec 2, 2019)
CLINICAL CORRESPONDENCE — Key Reattribution and Referral Documents	
Dr. Seely email Feb 21, 2021: cancer diagnosis characterised as error without oncological review	Dr. Seely email Feb 21, 2021 (A.5); Seely problem list Oct 29, 2021 (A.8); CHI Chart Export Jan–Nov 2021 (A.1)
NP Batsch NIHB referral Dec 15, 2020: oncological urgency acknowledged; HIV/VDRL outstanding documented	NP Batsch NIHB Referral Letter Dec 15, 2020 (A.5); CHI Chart Export Dec 2020 (A.1)
Urgent neurology referral Aug 24, 2022 (Dr. Filipowska to Dr. Bernstein): NPH impression 12 days after ‘normal’ Ottawa Valley MRI; ‘great difficulty getting support’	Urgent Neurology Referral Aug 24, 2022 (A.5)
TRT PRESCRIBING RECORD	
Five-prescriber, three-pharmacy TRT series; supratherapeutic testosterone Dec 2019 – mid-2021; no inter-prescriber coordination documented	Appendix A.15 (ten label images); Appendix C (testosterone serial values); Section 3 chronology (Dec 2, 2019 and Aug 2020 entries)